



## MANAGED CARE ANNUAL STATISTICAL REPORT

Published March 2002

The Managed Care Annual Statistical Report provides information about the medical managed care programs rendering care to Medi-Cal beneficiaries. It provides information on the number of persons enrolled in managed care, and a description of some of the demographic and eligibility characteristics of this population.

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STATISTICAL REPORT**  
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## Introduction

The Managed Care Annual Statistical Report provides information about the medical managed care programs rendering care to Medi-Cal eligibles. It also gives a description of the types of programs providing managed care services to Medi-Cal beneficiaries, the number of persons enrolled, and a description of some of the demographic and eligibility characteristics of this population.<sup>1</sup>

The Managed Care Annual Statistical Report does not present cost or utilization information for the Medi-Cal managed care population. Cost data for this population, as well as those in Fee-For-Service (FFS), are available in the Annual Statistical Report issued by this Section. Managed care utilization information is currently limited but will become available at a future date from the State Department of Health Services (DHS). Detailed information about dental managed care can be obtained from the DHS Payment Systems Division, Office of Medi-Cal Dental Services.

Please note the source for the enrollment and demographic charts and graphs in this report is the Monthly Medi-Cal Eligibles File, produced each month by the Department of Health Services. Eligibility data from this file for a previous month of eligibility was used to allow retroactive eligibles to be posted. In most cases, the month of eligibility for July 2001 was used from the file created late December 2001.

Other information related to Medi-Cal managed care is available on the [DHS Medical Care Statistics Section \(MCSS\) website](#). The report entitled “Report on the Use of Medi-Cal Managed Care Encounter Data for Research Purposes,” issued January 2002 (found under “[Publications](#)” on the MCSS website) reviews the quality and completeness of managed care encounter data. Current and historical counts of managed care beneficiaries by different variables are available in the “[Data Files](#)” section of the MCSS website.

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<sup>1</sup> The terms “eligible,” “beneficiary,” and “enrollee” are used interchangeably within Medi-Cal. Each refers to a person who meets all requirements for receiving a Medi-Cal medical service or good (e.g., drugs, DME items) and is enrolled in the Medi-Cal program. These terms are differentiated from the term “user,” who is a beneficiary actually receiving a service, drug, or DME item, etc.

## **Section 1, History and Description of Medi-Cal Managed Care**

Prior to 1994, Medi-Cal had predominately used a FFS health care delivery system to provide care to its beneficiary population. Under this system, qualified providers render care or provide all covered services such as physician services, drugs, and durable medical equipment (DME) items to beneficiaries, then bill the State; upon adjudication of their claims for services, the providers are paid the Medi-Cal approved rate.

The State believed that converting to a managed care system based on preventive and primary care would provide better health care for Medi-Cal beneficiaries. Managed care is a planned, comprehensive approach to the provision of health care combining clinical services and administrative procedures within an integrated, coordinated system to provide timely access to primary care and other necessary services in an effective manner. Under managed care, individual providers are linked together into a system that formalizes the often informal provider relationships that exist under FFS and brings them together under a single entity, the managed care plan. The plan manages the links and is accountable for performance and outcomes. Managed care's emphasis on access to primary care is intended to increase utilization of clinical preventive services and thus reduce both preventable hospitalizations and the unnecessary use of emergency rooms. In turn, this enables the plan to reallocate its resources to promote preventive and primary care for its members.

### **Section 1.1, History of Medi-Cal Managed Care**

The State Medicaid (Medi-Cal) program came into existence in March 1966 as a fee-for-service health care delivery system. In May 1972 Medi-Cal beneficiaries began enrolling in managed care plans when the first Prepaid Health Plan (PHP) contract went into effect. Joining a PHP was voluntary and limited to those in a public assistance aid category. In June 1983, a new type of managed care program, the County Organized Health System (COHS), began covering Medi-Cal beneficiaries when the Monterey Health Initiative became operational. This program stressed case management and utilization control in the delivery of health services to Medi-Cal eligibles. A few months later, in September 1983, the Santa Barbara Health Initiative also began operating a COHS. Both were similar in that almost all beneficiaries in the county were mandated to join the plan. Whereas the Monterey program stressed local control Primary Care Case Management (PCCM), Santa Barbara stressed centralized utilization control. The Monterey COHS ceased operations in July 1985 and has since been replaced with the Central Coast Alliance for Health, which covers both Monterey and Santa Cruz counties. A third COHS, the Health Plan of San Mateo, began operations in December 1987.

In August 1984, a third Medi-Cal managed care program began operation, the PCCM program. Like the PHP program, enrollment in PCCM plans was voluntary. The PCCMs were responsible for outpatient services only. Inpatient services for PCCM enrollees were delivered through the FFS program. The PCCM stressed assignment of

a personal physician to each beneficiary in the plan, and that physician authorized virtually all other services delivered by the PCCM plan.

State legislation in 1991 and 1992 enabled a substantial expansion of Medi-Cal managed care, primarily for AFDC-linked eligibles.<sup>2</sup> Pursuant to this legislation, the Department of Health Services (DHS) started the process of developing and implementing a Geographic Managed Care (GMC) program in two counties, a Two-Plan Model program in twelve counties, and the COHS program in three additional counties. (See [Appendix, Table A.1](#) for a list of the aid categories each of these plans cover.) In addition, a Special Project referred to as the Medi-Cal Fee-For-Service Managed Care Program (FFS-MC) began operations in the counties of Sonoma and Placer in March and October 1997, respectively.

The 1991 managed care legislation was significant in that prior to 1991 in a county in which Medi-Cal managed care plan enrollment was available, beneficiaries who did not choose between FFS and a plan were defaulted into FFS. With the 1991 legislation, the state was allowed under specific circumstances to direct the defaults into managed care.

## **Section 1.2, Description of Medi-Cal Managed Care**

Before 1994, there were three managed care programs providing medical care to the Medi-Cal population, the PHP program, the PCCM program, and the COHS program. From 1994 forward, two more programs were developed and implemented, the GMC program and the Two-Plan Model program. In 1995 and 1996, three additional counties formed COHS organizations. Currently, there are four managed care programs enrolling Medi-Cal eligibles: PHPs (full capitation, voluntary), COHSs (most aid categories, mandatory), GMC plans (Managed Care Family aid categories, mandatory) and Two-Plan Model plans (Managed Care Family aid categories, mandatory). There is only one PCCM program enrolling Medi-Cal eligibles as of June 2001. The following describes each of these programs.

### **Prepaid Health Plan**

The State Waxman-Duffy Act authorized Health Maintenance Organization (HMO) contracting in the Medi-Cal Program and referred to such plans as PHPs. In California, the PHP contracting program was established as an alternative to FFS. The intent of the program was to provide the Managed Care Family aid categories Medi-Cal beneficiaries

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<sup>2</sup> Other terms and programs, pursuant to recent Federal and State legislation, are replacing the term Aid to Families with Dependent Children (AFDC). For example, some persons formerly on AFDC are now on California's CalWorks' (made possible by Section 1931b of Title XIX of the Social Security Act), which implements the "Federal Temporary Assistance to Needy Families" (TANF) program. Other formerly AFDC eligibles are referred to as eligible under Section 1931b of Title XIX of the Social Security Act. What was formerly referred to as AFDC is referred to in this report as "Managed Care Family" aid categories.

who enrolled to have access to health care generally available in the public sector. PHPs are required to provide, on a capitated, at-risk basis, all basic Medi-Cal covered benefits, excluding such specified treatments as major organ transplants, chronic renal dialysis and long term care. (Refer to [Appendix, Table A.1](#) for a complete list of aid categories and their classifications.) In addition, PHPs provide case management, preventive and health maintenance services. As managed care contractors, PHPs have other requirements not found in FFS, such as quality of care management, membership services, and member grievance procedures. DHS administers the contracts with the PHP contractors and the Department of Managed Health Care oversees their operations as commercial health plans under the Knox-Keene Act. As of June 2001, beneficiaries in PHPs comprise 0.02% of all Medi-Cal beneficiaries, or about 900 members per month.

### **Primary Care Case Management**

The PCCM program is a managed care model that covers outpatient, physician, and some other outpatient services. PCCMs exclude inpatient services and some outpatient services from the scope of benefits provided under their capitated contracts. Under PCCM arrangements, primary care providers contract with DHS as managed care plans to provide and assume risk for primary care and specialty physicians' services as well as selected outpatient preventive and treatment services. (Refer to [Appendix, Table A.1](#) for a complete list of aid categories and their classifications.) PCCM contractors are required to case manage all services provided to their enrollees. Contractors participate in program savings through savings-sharing agreements with DHS. Shared savings must be produced by the PCCM's effective case management of services for which the PCCM is not at risk, the most significant of which is inpatient hospital care.

PCCM contracts operate under DHS review and oversight. Although PCCMs have not been directly subject to either the Knox-Keene or Waxman-Duffy Prepaid Health Plan Act, many of the relevant requirements are reflected in these contracts. Due to the implementation of the mandatory managed care programs, only one PCCM remains in operation, Positive Healthcare in Los Angeles county. As of June 2001, beneficiaries in this PCCM comprise 0.01% of all Medi-Cal beneficiaries, or about 610 members per month.

### **Geographic Managed Care**

Sacramento County was selected for the development of a GMC program in early 1992, and the program began enrolling in April 1994. Under Sacramento GMC, DHS contracts with seven managed care health plans for medical services and four dental care plans for dental services. The California Medical Assistance Commission negotiates capitation rates on behalf of DHS with each plan; rates are kept confidential. The mandatory aid category groups are: Managed Care Family aid categories, medically needy with no share of cost, medically indigent adult (confirmed pregnancy), medically indigent

children, and percent poverty children. (Refer to [Appendix, Table A.1](#) for a complete list of aid categories and their classification.) Medi-Cal beneficiaries allowed to join voluntarily include those who are in a Supplemental Security Income (SSI) or foster child aid category or who otherwise meet certain medical exemption criteria. Beneficiaries enrolled with a commercial or Medicare HMO are not allowed to enroll. In addition, eligibles in a mandatory aid category will not be enrolled in a plan during the months of retroactive eligibility or for the two months while they decide into which plan they want to enroll.

DHS received waivers of federal requirements for freedom of choice that permitted provision of Medi-Cal benefits to this population exclusively through GMC managed care plans. State legislation in 1994 permitted a second GMC program, referred to as "Healthy San Diego," to be formed in San Diego county. Enrollment began in mid-1998.

Under GMC, covered beneficiaries are informed about the available managed care plans and then are asked to select a plan. Beneficiaries are assisted in the selection process through the involvement of a Health Care Options (HCO) contractor, who provides them a presentation and explanatory materials about each of the plans. If a beneficiary does not select a plan, he/she is assigned to one.

Initially, five of the seven Sacramento GMC plans were fully-capitated PHP plans and two were PCCMs. Currently, there are six comprehensive plans in Sacramento county and seven in San Diego county that cover inpatient and all other medical services. DHS directly contracts with each of these GMC plans. As of June 2001, beneficiaries in GMCs comprise 5.77% of all Medi-Cal beneficiaries, or about 318,660 members per month.

## **County Organized Health Systems**

Under the COHS model, a county board of supervisors to contract with the Medi-Cal program creates a local agency, with representation from providers, beneficiaries, local government, and other interested parties. Operating under federal Medicaid freedom of choice and other waivers, the COHS administers a capitated, comprehensive, case managed health care delivery system. They are responsible for utilization control and claims administration, and must provide most Medi-Cal covered health care services. COHSs are health insuring organizations which manage and pay for services but do not directly provide care. Virtually all Medi-Cal beneficiaries with legal residency in the county must belong to the COHS. (Medi-Cal beneficiaries who are in recently established aid categories may not be covered due to a lack of historical data upon which to establish capitation rates.) Beneficiaries are given a wide choice of providers but do not have the option of obtaining Medi-Cal services under the traditional FFS system except for those services excluded from coverage, e.g., long term care (one plan only). Like the GMC program, the California Medical Assistance Commission negotiates capitation rates for each plan; rates are kept confidential.

Three COHSs operated in the 1980's in the counties of Monterey, Santa Barbara, and San Mateo. Monterey ceased operations in 1985. Enabling State legislation and federal HCFA waiver approvals later permitted three additional counties to form COHSs. The Solano Partnership Health Plan began operations in May 1994 and became Partnership Health Plan of California in March 1998, when Napa county was added. In October 1995, the California Orange Prevention and Treatment Integrated Medical Assistance Plan (CalOPTIMA) started enrolling Medical beneficiaries. In January 1996, the Santa Cruz County Health Options began operations; when Monterey county joined Santa Cruz in October 1999, the plan changed its name to Central Coast Alliance for Health. Yolo county joined the Partnership Health Plan of California in March 2001.

COHSs currently exist in Monterey, Napa, Orange, San Mateo, Santa Barbara, Santa Cruz, Solano and Yolo counties. As of June 2001, beneficiaries in COHSs comprise 8.37% of all Medi-Cal beneficiaries, or about 461,970 members per month.

## **Two-Plan Model**

A plan for a new type of Medi-Cal managed care program was developed by DHS and a report was issued March 31, 1993 entitled Expanding Medi-Cal Managed Care. Under this program, two HMO plans operate in each of the selected counties. One is operated under the auspices of the county government or a community based entity, e.g., an independent health commission; the other is a commercial HMO selected by DHS through competitive bid. The two plans are directly monitored by DHS and have the same contract requirements. The publicly sponsored plan is referred to as the local initiative (LI), and the private HMO as the commercial plan (CP). It was envisioned that the LI would provide a means for hospitals, clinics, and physicians who traditionally cared for Medi-Cal beneficiaries under FFS, as well as the safety net providers who provide care to both Medi-Cal beneficiaries and other medically indigent persons, to continue providing these services under managed care. In the case of hospitals, this arrangement helps support receipt of federal disproportionate share hospital funds. Contract provisions also promote use of cultural and linguistic services for those beneficiaries needing them. Both the LI and CP plans provide full medical services, including inpatient, and must be Knox-Keene licensed. Contract rates are established by DHS.

The mandatory aid category groups are: Managed Care Family aid categories, medically needy with no share of cost, medically indigent adult (confirmed pregnancy), medically indigent children, and percent poverty children. (Refer to [Appendix, Table A.1](#) for a complete list of aid categories and their classification.) Those allowed to join voluntarily include those who are in an SSI or foster child aid category or who meet certain medical exemption criteria.

The counties selected by DHS for the Two-Plan Model initially included Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, San Bernardino, San Diego, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare. Subsequently, San Diego was legislatively chosen to implement the GMC program ([see above](#)). Fresno chose not to implement a local initiative, thereby resulting in DHS selecting a second commercial plan for that county. The commercial plan in Stanislaus county ceased operations in March 2000; as a result, beneficiaries in mandatory aid codes were allowed to elect to enroll into the remaining local initiative or FFS; if a beneficiary did not make a selection, they were defaulted into the local initiative. As of June 2001, beneficiaries in Two-Plan model plans comprise 37.30% of all Medi-Cal beneficiaries, or about 2,058,740 members per month.

## **Special Projects**

DHS is developing new types of managed care programs for Medi-Cal beneficiaries. These managed care programs strive to promote improved health status and to avoid non-duplicative or otherwise unnecessary costs. Two types of special projects currently implemented in DHS are:

Medical Case Management of High Cost Beneficiaries -- DHS has established other programs to manage high-cost Medi-Cal beneficiaries within the FFS environment. Under this program, DHS develops and conducts pilot projects under which these populations receive medical case management. Examples include those with AIDS and the elderly at risk of entering long-term care, e.g., On Lok and Scan Health plans

Fee-For-Service Managed Care (FFS-MC) -- To improve the coordination of care for those beneficiaries in FFS and to improve continuity of care, DHS established fee-for-service, "gatekeeper model" managed care programs in Sonoma and Placer Counties, starting March and October 1997, respectively. This program pays the contracted local government a fee per eligible per month for: 1) establishing a primary care physician network from which beneficiaries select or are assigned to a personal physician; and 2) case managing the services received by the Medi-Cal beneficiaries, thereby improving coordination of care.

As of June 2001, beneficiaries in Special Projects comprise 0.73% of all Medi-Cal beneficiaries, or about 40,300 members per month.

**Scope of Services Covered by Managed Care**

The scope of services covered by Medi-Cal managed care health plans is determined by their contract with DHS. Comprehensive plans typically cover inpatient care, limited skilled nursing services, and most outpatient services. Exceptions may vary from plan to plan and between managed care models. Plans are required to provide all medically necessary care, but may restrict such coverage to no more than what Medi-Cal would cover or may expand the coverage provided. Plans are not required to cover some services such as Psychiatric and AIDS drugs. Carved out services are listed in the EDS (FFS) Provider Manuals, available at <http://www.medi-cal.ca.gov/>, or can be obtained by calling the DHS Medi-Cal Managed Care Division.

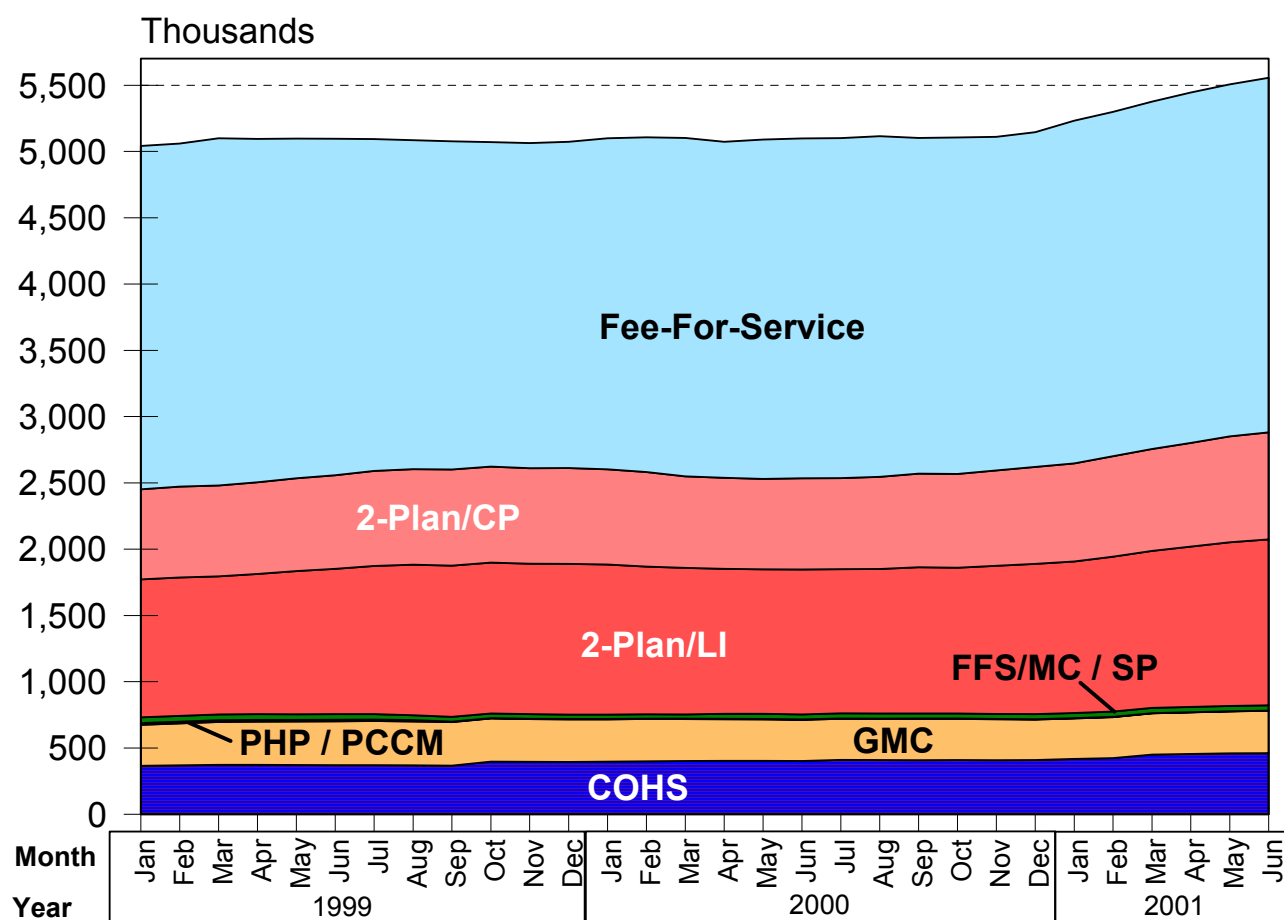
## Section 1.3, Enrollment Data

**Table 1.1, Medi-Cal Eligibles by Program – FFS vs. Managed Care Programs**

The following graph shows the monthly enrollment (January 1999 forward) in Medi-Cal for medical FFS and managed care plans. Each type of managed care program is shown separately. Total June 2001 enrollment was: COHS – 461,970; GMC – 318,663; Two-Plan/Local Initiative – 1,251,170; Two-Plan/Commercial Plan – 807,565; FFS/MC – 37,201; SP – 3,102; PHP – 899; PCCM – 610.

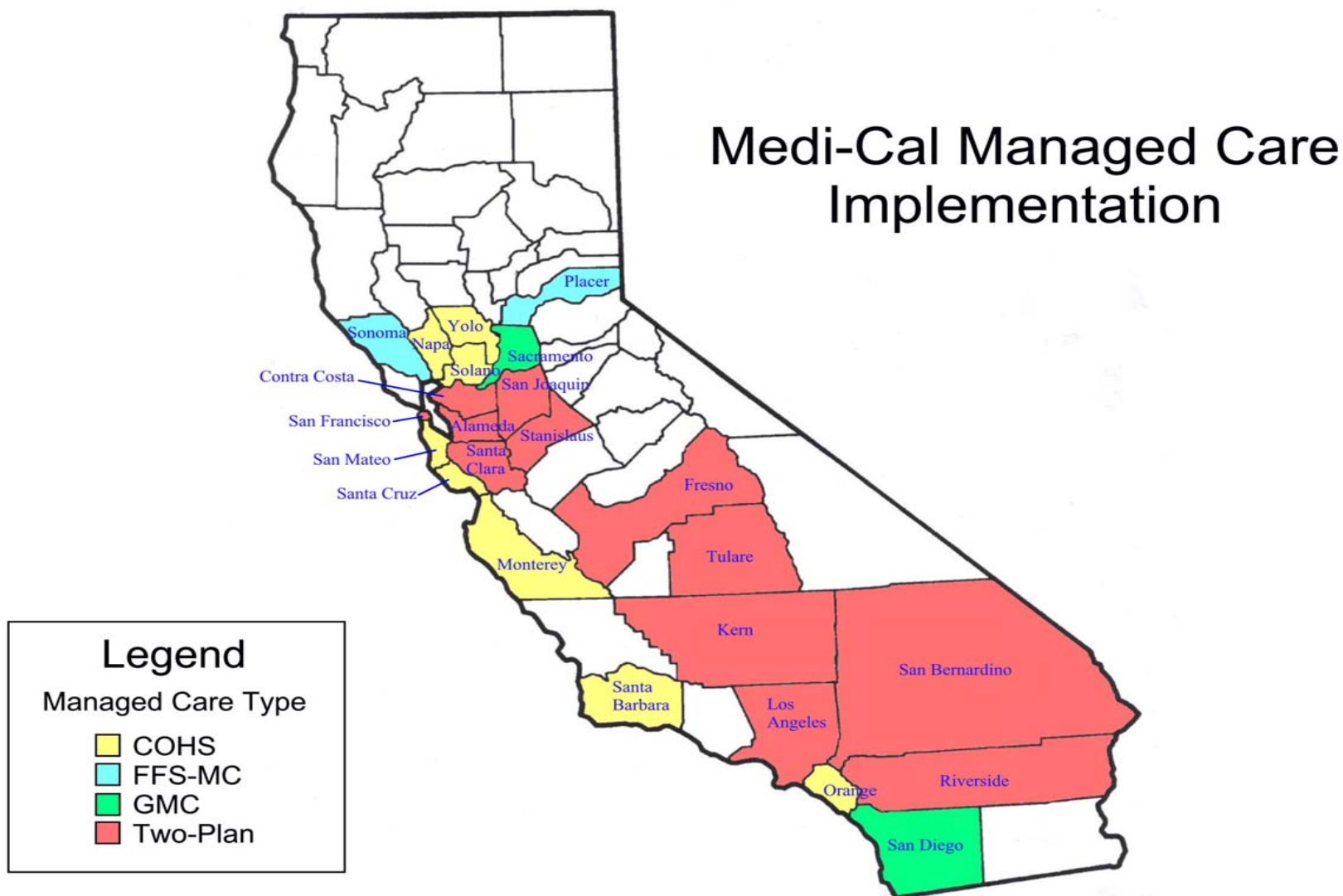
Source: July 2001 month of eligibility Medi-Cal Eligibles File, using a six-month lag.  
FFS/MCN eligible counts source is the Monthly Enrollment Report Provided by the Managed Care Fiscal Monitoring Unit.

### Medi-Cal Eligibles Monthly Enrollment Fee-For-Service vs. Managed Care Program



**Table 1.2, Map of California's Managed Care Counties**

The following map of California shows each county with a managed care plan in operation.  
 (Note: Excludes PHP and PCCM programs.)



**Table 1.3, Major Managed Care Plans, by County**

The following tables show Medi-Cal managed care plans by county (Table 1.3A) and by plan then county (Table 1.3B). The managed care programs included here are: COHS, FFS-MC, GMC, and Two-Plan Model. Excluded are PHP, PCCM, and special projects (e.g., AIDS, SCAN).

**Table 1.3A, Major Managed Care Plans by County**

County	Program	LI/ CP*	Plan Name	Start Date	Enrollment** as of July 2001
<b>Alameda</b>	2-PLAN	LI	Alameda Alliance for Health	1/96	67,655
		CP	Blue Cross of California	7/96	27,536
<b>Contra Costa</b>	2-PLAN	LI	Contra Costa Health Plan	2/97	39,973
		CP	Blue Cross of California	6/98	4,911
<b>Fresno</b>	2-PLAN	CP	Health Net	1/97	29,149
		CP	Blue Cross of California	11/96	118,027
<b>Kern</b>	2-PLAN	LI	Kern Health Systems	7/96	58,145
		CP	Blue Cross of California	9/96	29,906
<b>Los Angeles</b>	2-PLAN	LI	LA Care Health Plan	4/97	709,768
		CP	Health Net	7/97	465,630
<b>Monterey</b>	COHS		Central Coast Alliance For Health	10/99	47,866
<b>Napa</b>	COHS		Partnership Health Plan of California	3/98	8,303
<b>Orange</b>	COHS		CalOPTIMA	10/95	239,292
<b>Placer ***</b>	FFS/MC		Placer County Managed Care Network	10/97	11,576
<b>Riverside</b>	2-PLAN	LI	Inland Empire Health Plan	9/96	80,534
		CP	Molina Healthcare	3/98	30,581
<b>Sacramento</b>	GMC		Blue Cross of California	4/94	71,637
			Health Net	5/96	28,920
			Kaiser Foundation Health Plan	4/94	19,722
			Maxicare Health Plans	6/98	7,888
			Blue Cross (thru 3/01 - formerly OMNI)	4/94	0
			Western Health Advantage	5/97	14,937
			Molina Healthcare	2/00	15,208

**Table 1.3A, Major Managed Care Plans by County (continued)**

County	Program	LI/ CP*	Plan Name	Start Date	Enrollment** as of July 2001
San Bernardino	2-PLAN	LI	Inland Empire Health Plan	9/96	110,511
		CP	Molina Healthcare	3/98	42,531
San Diego****	GMC		Blue Cross of California	7/98	13,041
			Community Health Group	7/98	65,423
			Health Net	7/98	7,708
			Kaiser Foundation	7/98	8,212
			Sharp Health Plan	7/98	44,654
			UCSD Healthcare	7/98	12,160
			Universal Care	7/98	11,146
San Francisco	2-PLAN	LI	San Francisco Health Plan	1/97	25,620
		CP	Blue Cross of California	7/96	14,904
San Joaquin	2-PLAN	LI	Health Plan of San Joaquin	2/96	49,209
		CP	Blue Cross of California	1/97	14,285
San Mateo	COHS		Health Plan of San Mateo	12/87	38,421
Santa Barbara	COHS		Santa Barbara Health Initiative	9/83	44,591
Santa Clara	2-PLAN	LI	Santa Clara Family Health Plan	2/97	41,716
		CP	Blue Cross of California	10/96	21,154
Santa Cruz	COHS		Central Coast Alliance for Health	1/96	23,004
Solano	COHS		Partnership Health Plan of California	5/94	40,881
Sonoma ***	FFS/MC		Sonoma Partners for Health Managed Care	3/97	25,613
Stanislaus	2-PLAN	LI	Blue Cross of California/SLI	10/97	27,903
Tulare	2-PLAN	LI	Blue Cross of California	3/99	49,134
		CP	Health Net	2/99	16,718
Yolo	COHS		Partnership Health Plan of California	3/01	21,083

\* "LI" stands for Local Initiative; "CP" stands for Commercial Plan.

\*\* Source for number of eligibles for all plans except FFS/MC is the Monthly Medi-Cal Eligibility File.

\*\*\* Source for FFS/MC eligible counts is the Monthly Enrollment Report provided by the Managed Care Fiscal Monitoring Unit.

\*\*\*\* The official name for the San Diego GMC is "Healthy San Diego".

**Table 1.3B, Major Managed Care Plans by County**

<b>Plan Name</b>	<b>Program</b>	<b>LI/CP*</b>	<b>County</b>	<b>Enrollment** as of July 2001</b>
Alameda Alliance for Health	2-PLAN	LI	<b>Alameda</b>	67,655
Blue Cross of California		TOTAL		392,438
	2-PLAN	CP	<b>Alameda</b>	27,536
	2-PLAN	CP	<b>Contra Costa</b>	4,911
	2-PLAN	CP	<b>Fresno</b>	118,027
	2-PLAN	CP	<b>Kern</b>	29,906
	GMC		<b>Sacramento</b>	71,637
	GMC		<b>San Diego****</b>	13,041
	2-PLAN	CP	<b>San Francisco</b>	14,904
	2-PLAN	CP	<b>San Joaquin</b>	14,285
	2-PLAN	CP	<b>Santa Clara</b>	21,154
	2-PLAN	LI	<b>Stanislaus</b>	27,903
	2-PLAN	LI	<b>Tulare</b>	49,134
CalOPTIMA	COHS		<b>Orange</b>	239,292
Central Coast Alliance For Health		TOTAL		70,870
	COHS		<b>Monterey</b>	47,866
	COHS		<b>Santa Cruz</b>	23,004
Community Health Group	GMC		<b>San Diego****</b>	65,423
Contra Costa Health Plan	2-PLAN	LI	<b>Contra Costa</b>	39,973
Health Net		TOTAL		548,125
	2-PLAN	CP	<b>Fresno</b>	29,149
	2-PLAN	CP	<b>Los Angeles</b>	465,630
	GMC		<b>Sacramento</b>	28,920
	GMC		<b>San Diego****</b>	7,708
	2-PLAN	CP	<b>Tulare</b>	16,718
Health Plan of San Joaquin	2-PLAN	LI	<b>San Joaquin</b>	49,209
Health Plan of San Mateo	COHS		<b>San Mateo</b>	38,421
Inland Empire Health Plan		TOTAL		191,045
	2-PLAN	LI	<b>Riverside</b>	80,534
	2-PLAN	LI	<b>San Bernardino</b>	110,511

**Table 1.3B, Major Managed Care Plans by County (continued)**

<b>Plan Name</b>	<b>Program</b>	<b>LI/CP*</b>	<b>County</b>	<b>Enrollment** as of July 2001</b>
Kaiser Foundation Health Plan		TOTAL		27,934
	GMC		Sacramento	19,722
	GMC		San Diego****	8,212
Kern Health Systems	2-PLAN	LI	Kern	58,145
LA Care Health Plan	2-PLAN	LI	Los Angeles	709,768
Maxicare Health Plans	GMC		Sacramento	7,888
Molina Healthcare		TOTAL		88,320
	2-PLAN	CP	San Diego****	30,581
	GMC		Sacramento	15,208
	2-PLAN	CP	San Bernardino	42,531
Partnership Health Plan of California		TOTAL		70,267
	COHS		Napa	8,303
	COHS		Solano	40,881
	COHS		Yolo	21,083
Placer County Managed Care Network	FFS/MC		Placer***	11,576
San Francisco Health Plan	2-PLAN	LI	San Francisco	25,620
Santa Barbara Health Initiative	COHS		Santa Barbara	44,591
Santa Clara Family Health Plan	2-PLAN	LI	Santa Clara	41,716
Sharp Health Plan	GMC		San Diego****	44,654
Sonoma Partners for Health Managed Care	FFS/MC		Sonoma***	25,613
UCSD Healthcare	GMC		San Diego****	12,160
Universal Care	GMC		San Diego****	11,146
Western Health Advantage	GMC		Sacramento	14,937

\* "LI" stands for Local Initiative; "CP" stands for Commercial Plan.

\*\* Source for number of eligibles for all plans except FFS/MC is the Monthly Medi-Cal Eligibility File.

\*\*\* Source for FFS/MC eligible counts is the Monthly Enrollment Report provided by the Managed Care Fiscal Monitoring Unit.

\*\*\*\* The official name for the San Diego GMC is "Healthy San Diego".

## **Table 1.4, Aid Category Groups by FFS and Managed Care in GMC, Two-Plan, and COHS Counties**

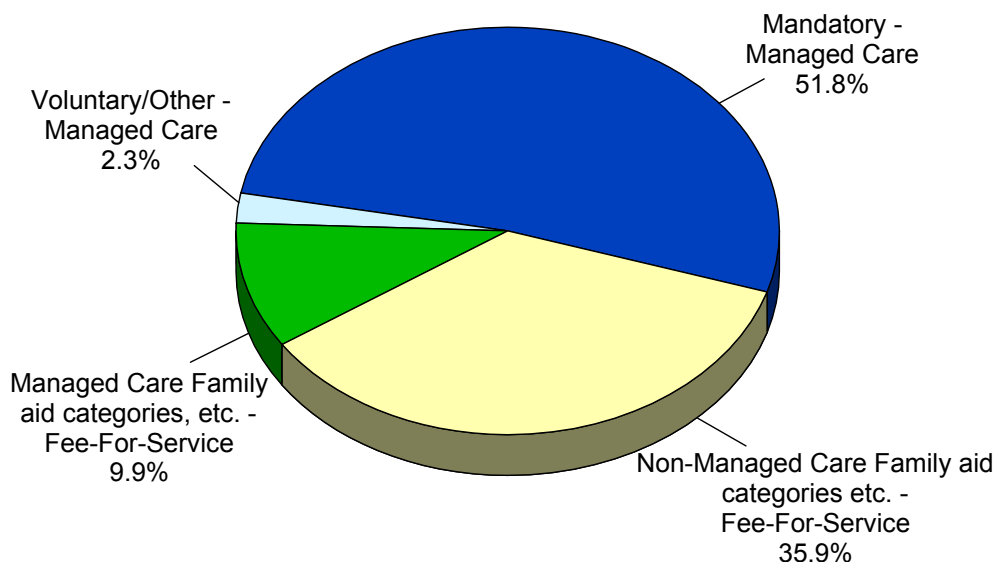
The following pie charts show the distribution of Medi-Cal beneficiaries broken out by managed care enrollment vs. FFS and mandatory vs. voluntary/other aid category group, for counties implemented to managed care as of July 2001. (See [Table 1.5](#) for a list of these counties.) As this indicates, the percent of those in managed care is 54% (2.3% + 51.8%) for the Two-Plan and GMC counties and 86% (0.1% + 85.8%) for the COHS counties for all aid categories. The COHS mandatory managed care population will always be larger than that of the Two-Plan and GMC models since virtually all Medi-Cal beneficiaries in the county must belong to the COHS. For a more detailed description of the COHS plans, please see [Section 1.2, Description of Medi-Cal Managed Care, County Organized Health Systems](#) of this report. (See [Appendix, Table A.1](#) for definitions of the aid category groupings.)

Source of these data is the July 2001 month of eligibility Medi-Cal Eligibles File, using a four-month lag.

### Two-Plan and GMC Counties

#### Eligibles in Fee-For-Service and Managed Care

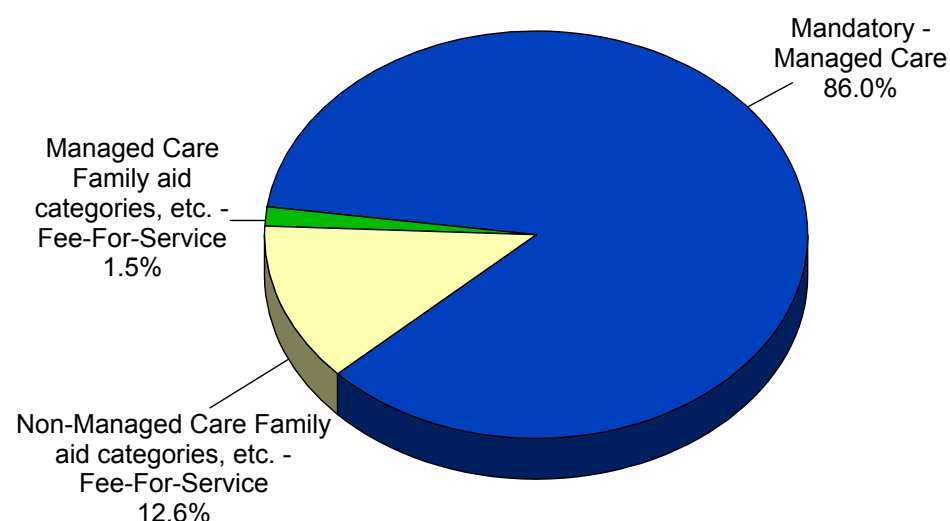
Percent Mandatory (Managed Care Family aid categories, etc.) vs. Voluntary/Other (Non-Managed Care Family aid categories, etc.)



### COHS Counties

#### Eligibles in Fee-For-Service and Managed Care

Percent Mandatory (Managed Care Family aid categories, etc.) vs. Other\* Aid Group (Non-Managed Care Family aid categories, etc.)



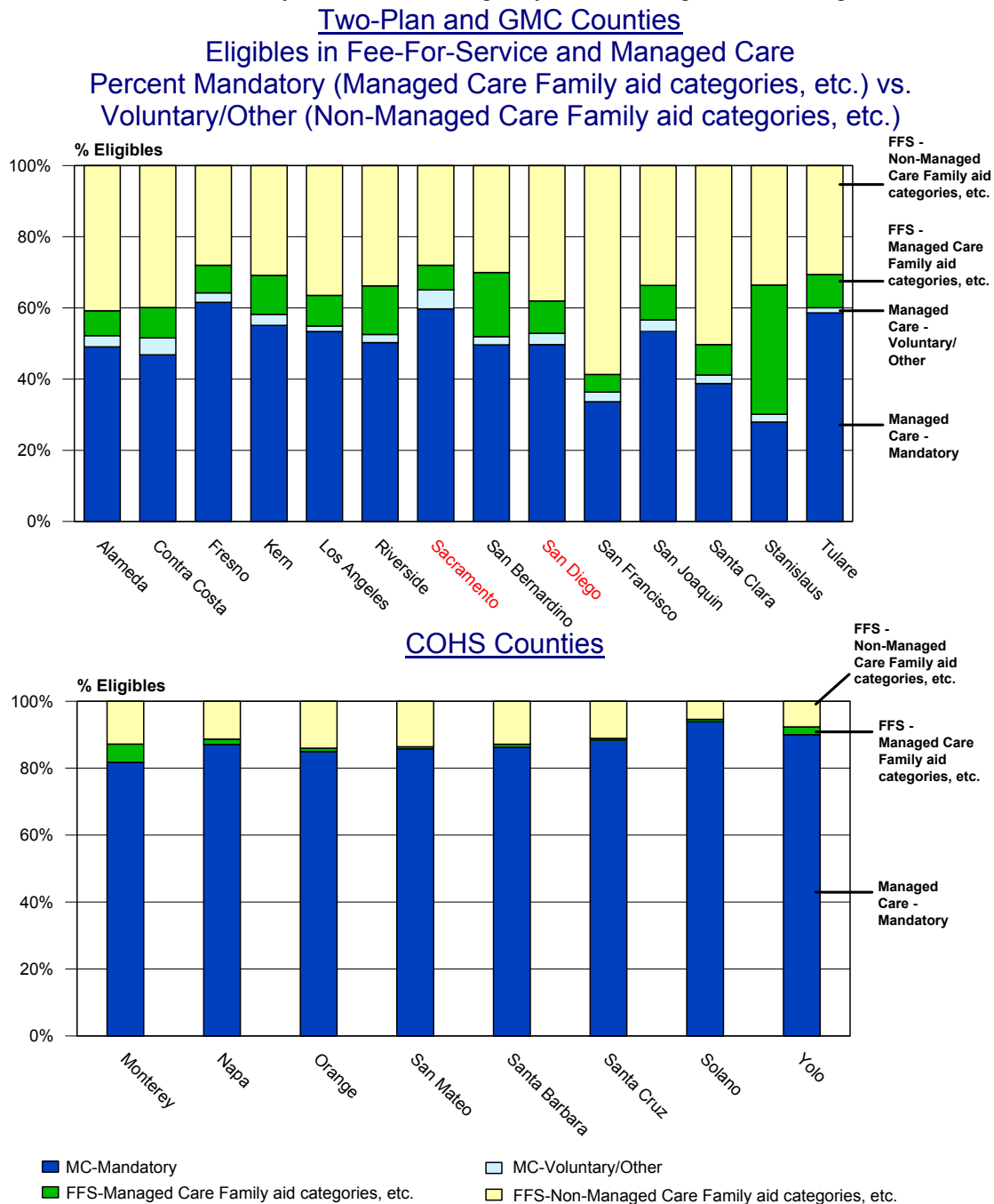
\* COHS plans do not include voluntary aid codes.



**Table 1.5, Aid Category Groups by FFS and Managed Care in GMC, Two-Plan, and COHS Counties**

The following bar chart provides the distribution of Medi-Cal beneficiaries broken out by managed care enrollment vs. FFS, and mandatory vs. voluntary/other aid category group (four aid categories in all), for counties implemented to managed care as of July 2001. The chart shows that in most counties over 40% of these beneficiaries are in managed care. The commercial plan in Stanislaus county ceased operations in March 2000; as a result, beneficiaries in mandatory aid codes can elect to enroll into the remaining local initiative or FFS. (See [Appendix, Table A.1](#) for definitions of the aid category groupings.)

Source of these data is the July 2001 month of eligibility Medi-Cal Eligibles File using, a four-month lag.



GMC: Sacramento & San Diego counties.

\* COHS plans do not include voluntary aid codes.

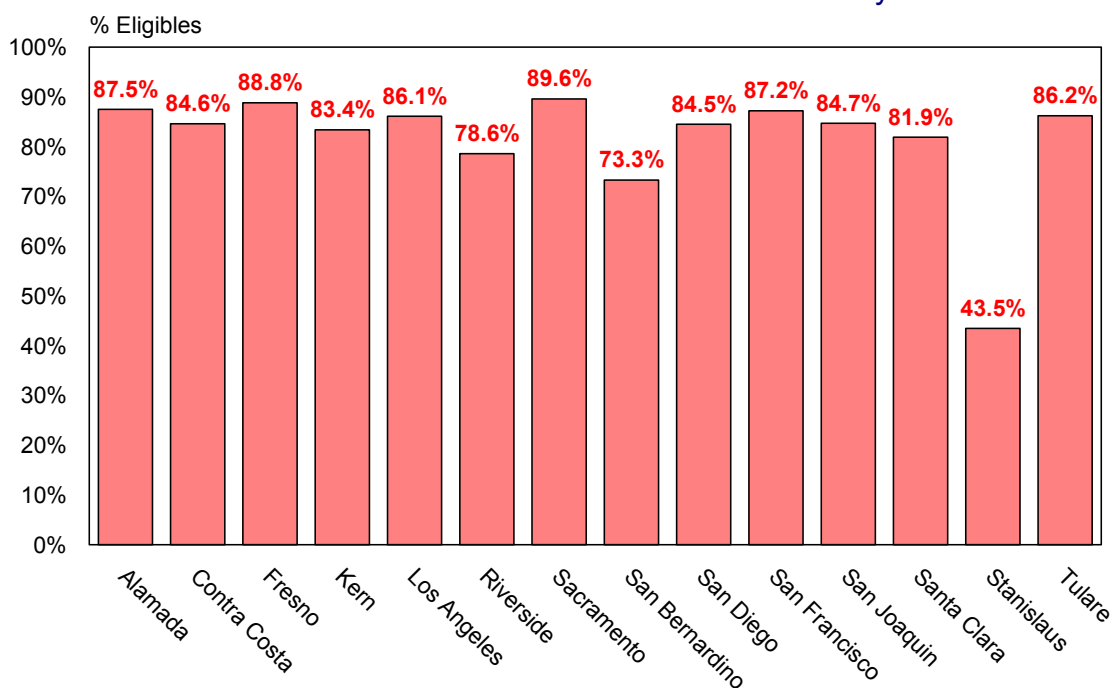
**Table 1.6, Percent Mandatory Eligibles in Managed Care of All Mandatory Eligibles in GMC and Two-Plan Model Counties Only**

Of those eligibles in a mandatory aid category, the following chart shows the percent of those actually enrolled in a managed care plan. The average county enrollment of mandatory aid code eligibles in the Two-Plan Model and GMC Counties has increased by 5% for implemented counties since July 2000 (see the [Managed Care Annual Statistical Report published April 2001](#)).

The percent of beneficiaries in a mandatory aid category is always less than 100%. Not every beneficiary in a mandatory aid category will end up in a managed care plan. Reasons for this include: 1) managed care implementation is still in process; 2) the beneficiary received Medi-Cal eligibility retroactively (that is, between the start of the eligibility month and some months later); 3) the beneficiary has other health coverage (usually CHAMPUS, Medicare HMO, Kaiser, or some PHP/HMO and Exclusive Provider Option coverage) that excludes them from enrolling in a plan; 4) the beneficiary just became eligible for Medi-Cal in a particular county, and is still in the process of selecting a plan or will be defaulted into one; 5) the beneficiary lives in an exempted zip code; 6) the beneficiary has a medical exemption granted by the DHS (for a complete list of these exemptions, contact the DHS Medi-Cal Managed Care Division); 7) a person born to a mother on managed care is covered under FFS the month of delivery and the following month, and then is put into managed care only after the legal guardian(s) successfully completes the Medi-Cal enrollment process (usually three to six months after birth); 8) a person switches from a non-mandatory to a mandatory aid code and is still in the process of selecting a plan; 9) in the case of Stanislaus county, the commercial plan ceased operations in March 2000; as a result, beneficiaries in mandatory aid codes can elect to enroll into the remaining local initiative or FFS.

Source of these data is the July 2001 month of eligibility Medi-Cal Eligibles File, using a four-month lag.

**Percent Mandatory Eligibles In Managed Care  
Two-Plan Model and GMC Counties Only**



**Table 1.7, Enrollment for Two-Plan Counties**

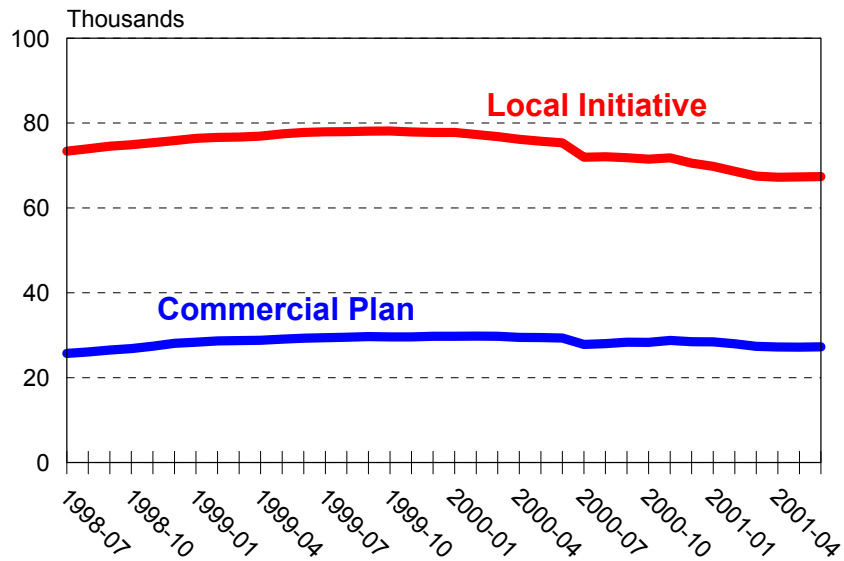
The following charts depict monthly enrollment by county and Commercial Plan vs. Local Initiative for July 1998 through June 2001. As these charts show, in most cases, the Local Initiative has more Medi-Cal beneficiaries than the Commercial Plan. On a statewide basis, the Local Initiative plans have about two members for every one in the Commercial Plans. This may be explained by the fact that the Local Initiative usually started up before the Commercial Plan. The Fresno county model has two Commercial Plans and no Local Initiative. Stanislaus county has had only a Local Initiative since March 2000, when the Commercial Plan ceased operations.

Source of these data is the July 2001 month of eligibility Medi-Cal Eligibles File, using a six-month lag.

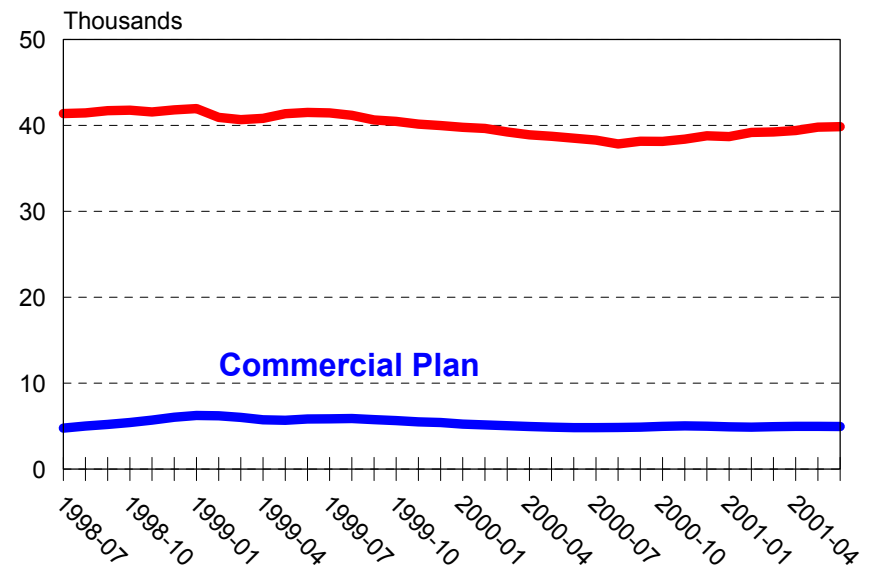


**Table 1.7, Enrollment for Two-Plan Counties (continued)**

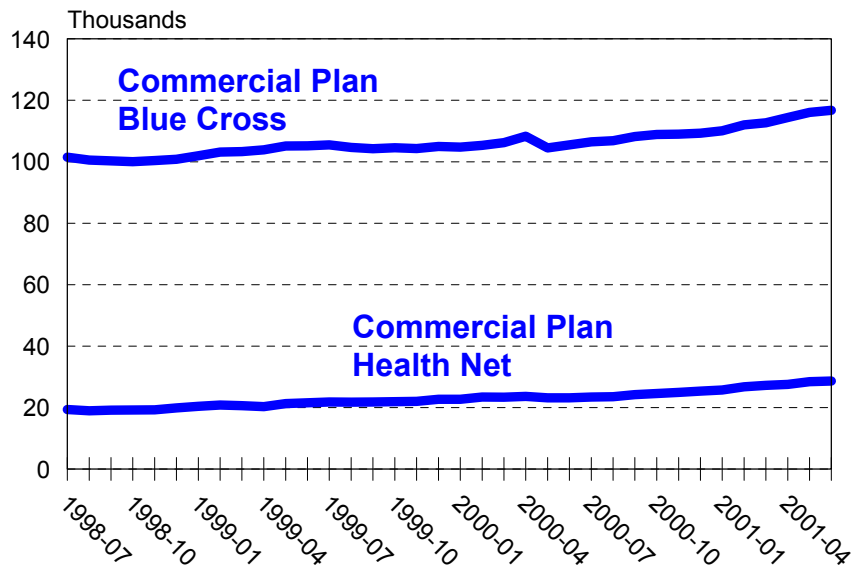
### Alameda County



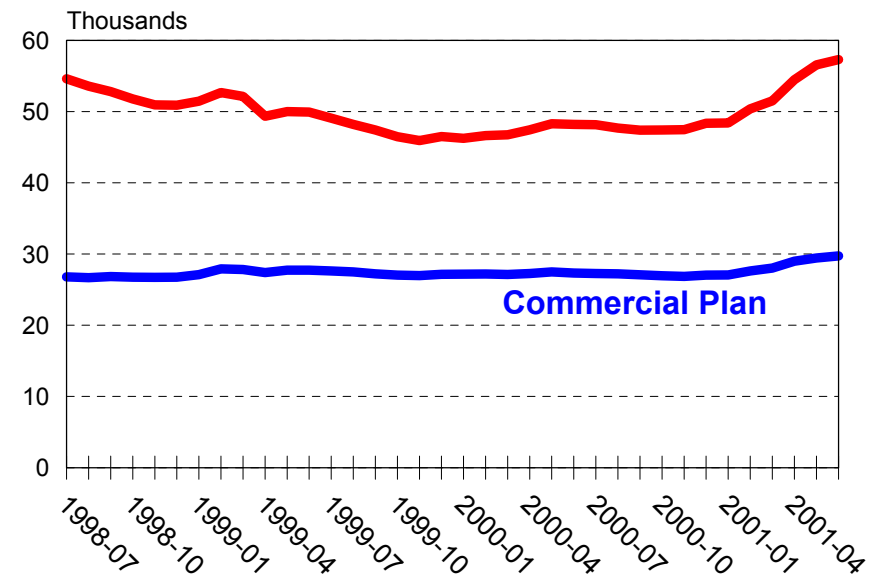
### Contra Costa County



### Fresno County



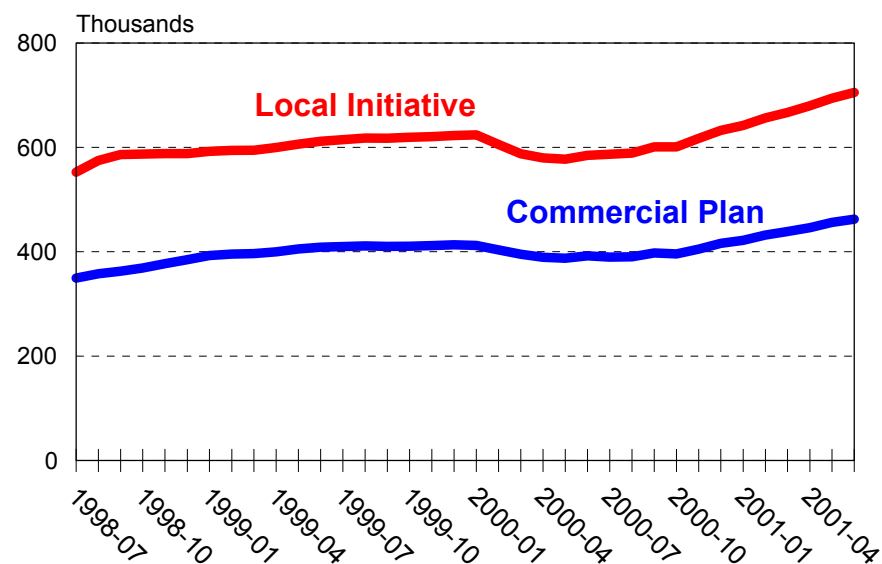
### Kern County



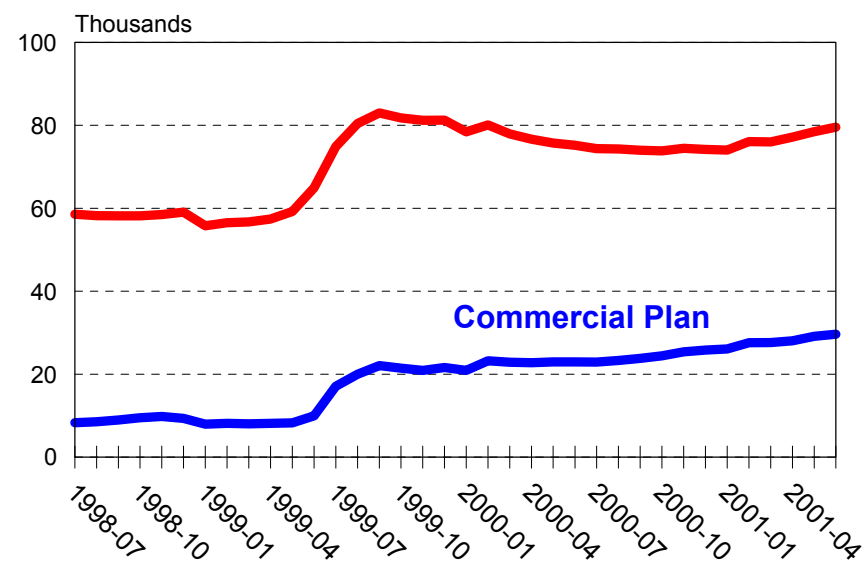


**Table 1.7, Enrollment for Two-Plan Counties (continued)**

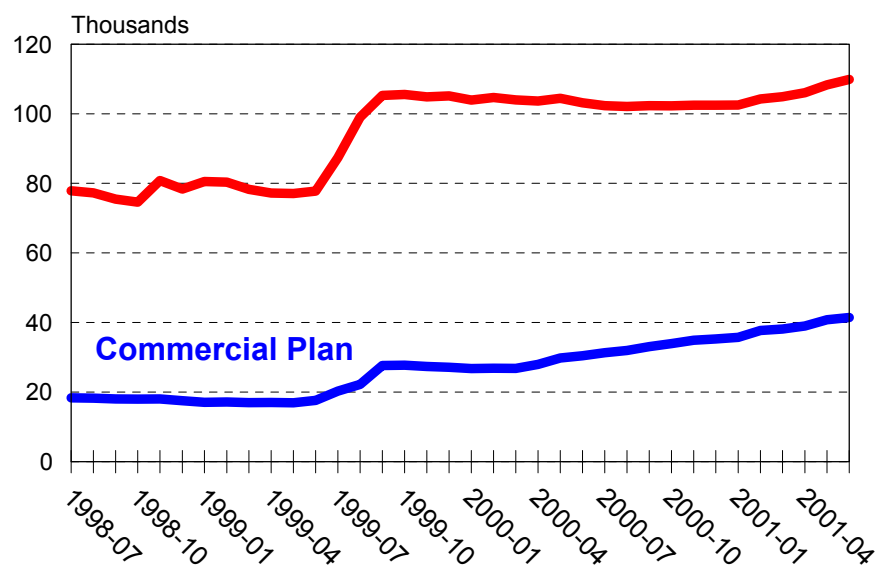
### Los Angeles County



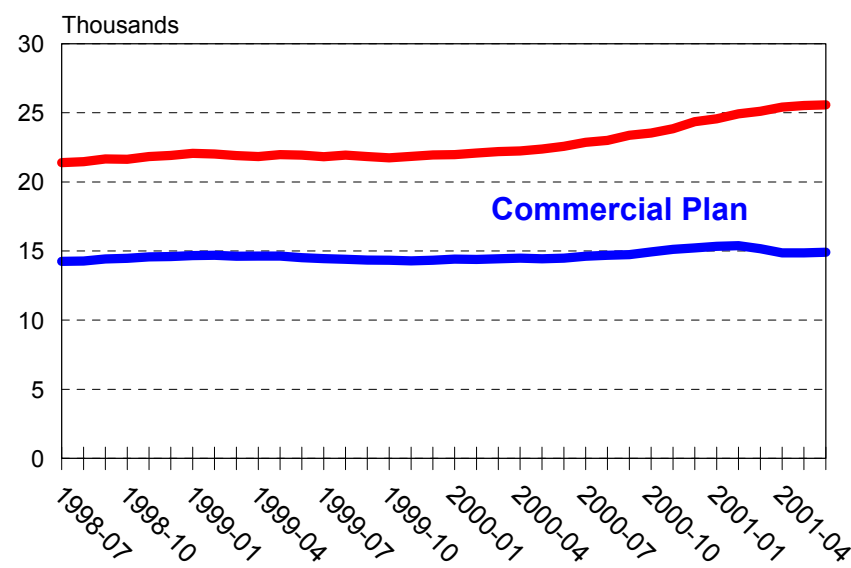
### Riverside County



### San Bernardino County



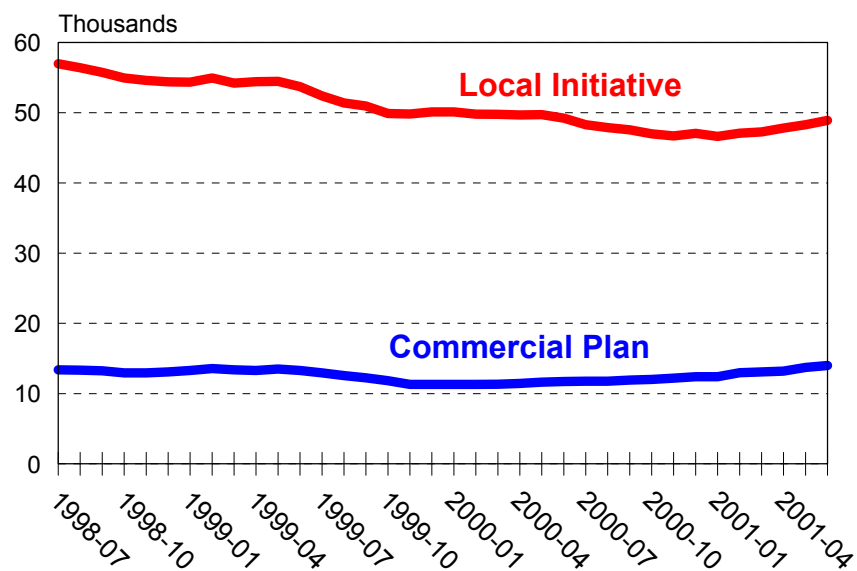
### San Francisco County



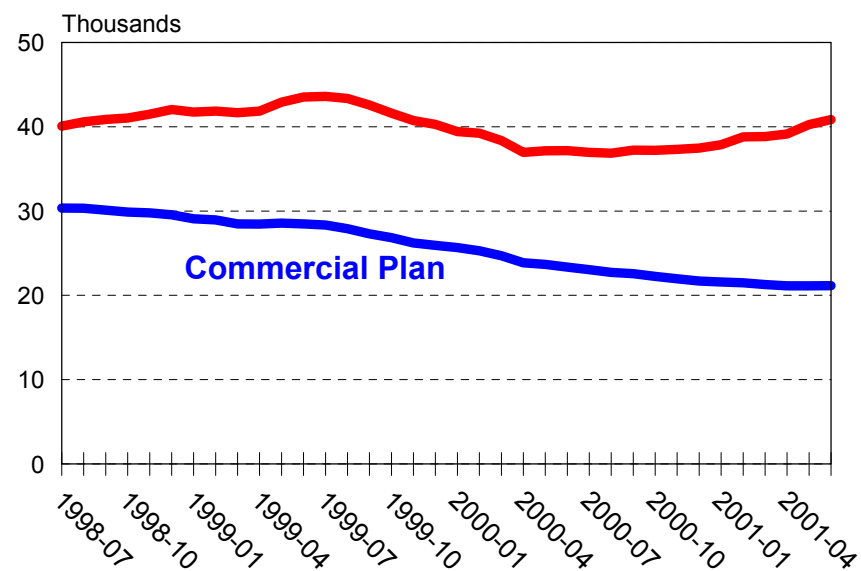


**Table 1.7, Enrollment for Two-Plan Counties (continued)**

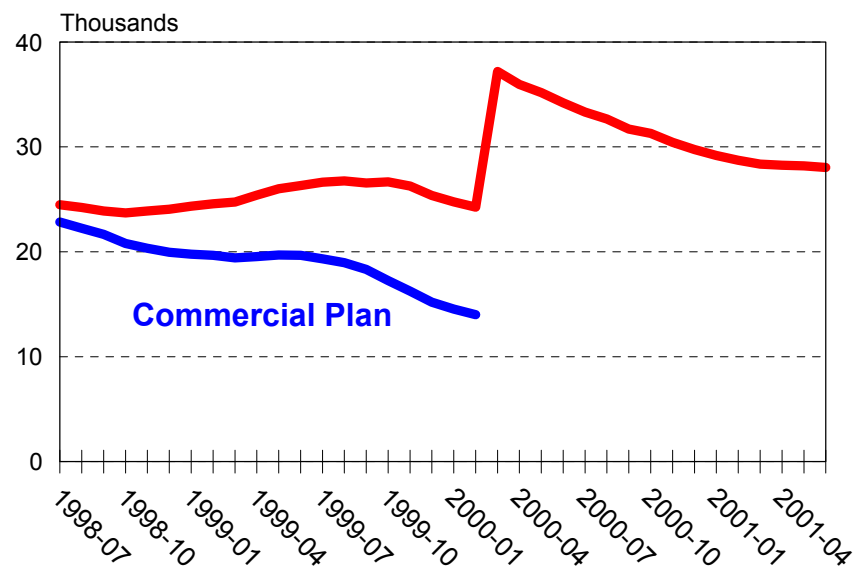
### San Joaquin County



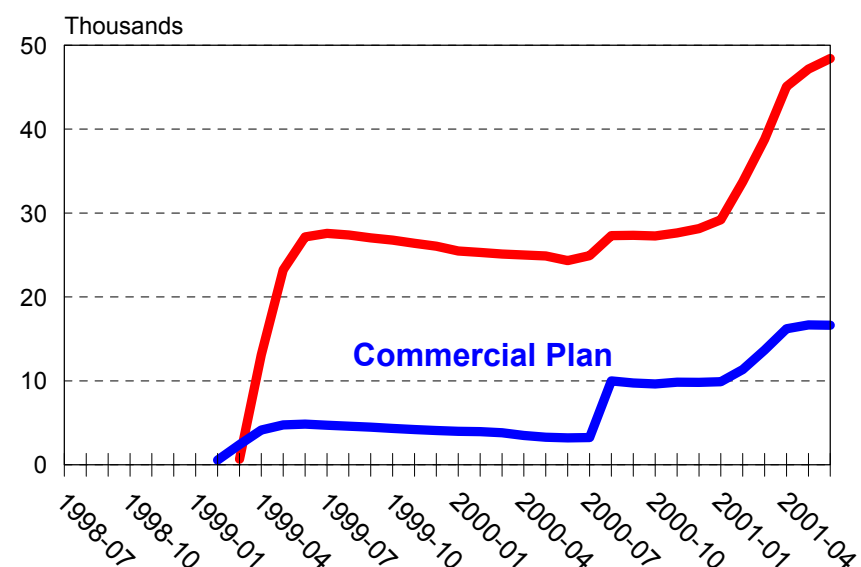
### Santa Clara County



### Stanislaus County



### Tulare County



**Table 1.8, Monthly Enrollment for GMC Counties**

The following charts depict enrollment by county for the individual GMC health plans for July 1998 through June 2001.

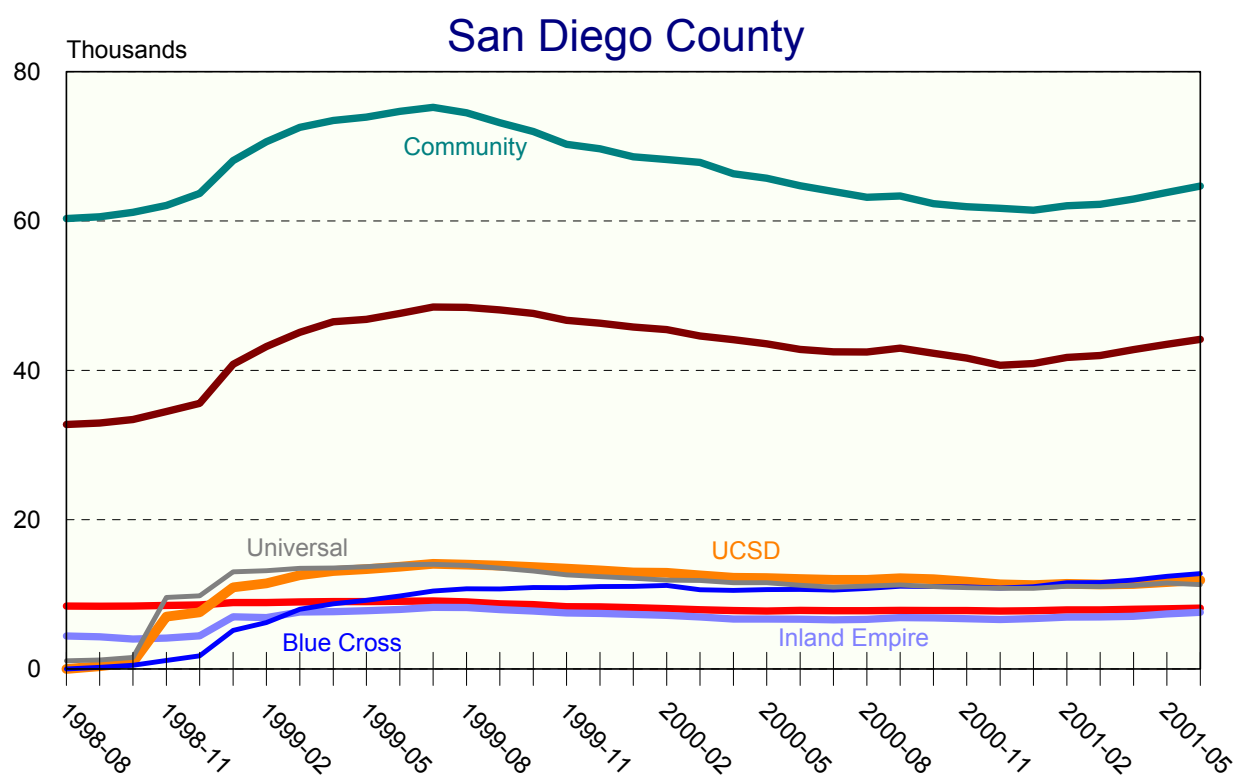
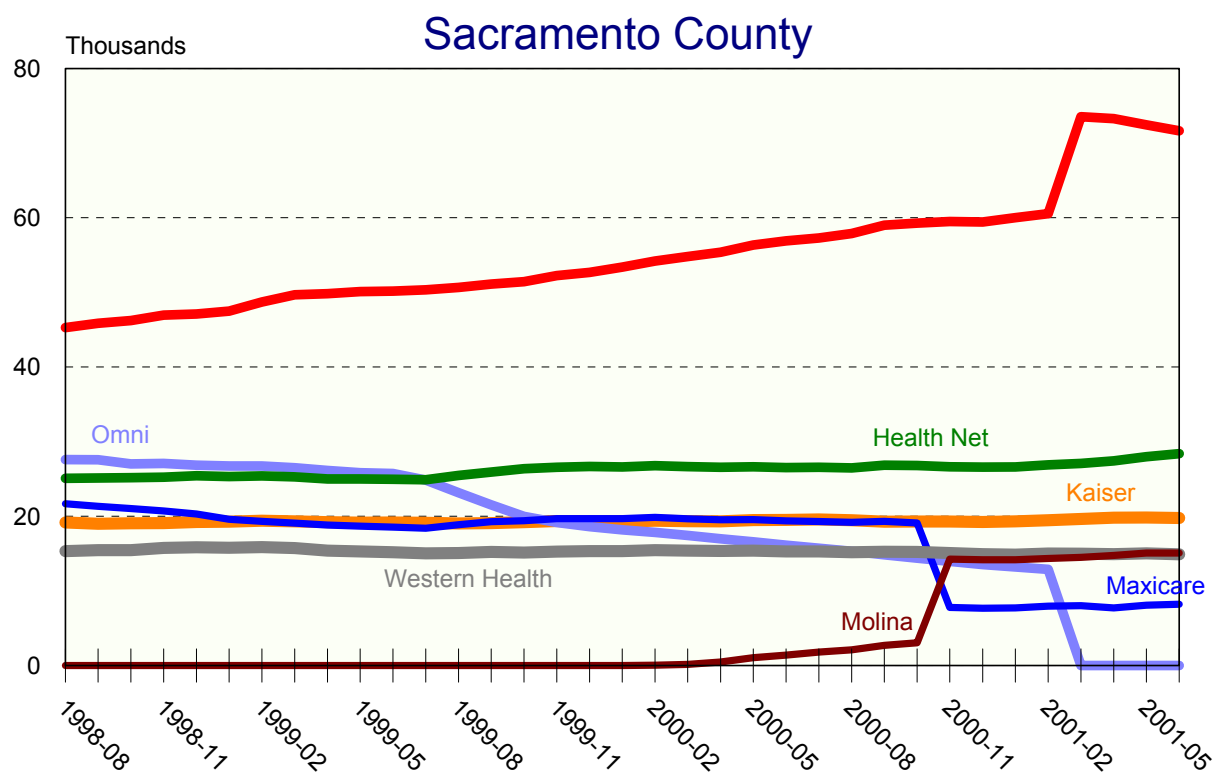
As indicated in these tables, most Sacramento GMC plans have had steady monthly enrollment since August 1998. Together, four of the seven plans (Molina, Kaiser, Health Net, and Western Health) enroll about 50% of all Sacramento GMC beneficiaries. Blue Cross shows a steady increase in enrollment, from 45,268 (29% of the Sacramento GMC population) in July 1998 to 71,663 (45%) in June 2001.

The Healthy San Diego GMC plans began enrolling members in August 1998 with five fully capitated PHPs already operating in San Diego county. Two more plans began enrolling in September 1998. Currently, there are seven GMC plans in operation in San Diego county. Five of the seven plans (Universal, Blue Cross, UCSD, Inland Empire, and Kaiser) represent a combined enrollment of 32% of the Healthy San Diego population, while 40% of the enrollees are in Community Health Group and the remaining 28% are in Sharp Health Plan.

Source of these data is the July 2001 month of eligibility Medi-Cal Eligibles File, using a six-month lag.



**Table 1.8, Monthly Enrollment for GMC Counties (continued)**

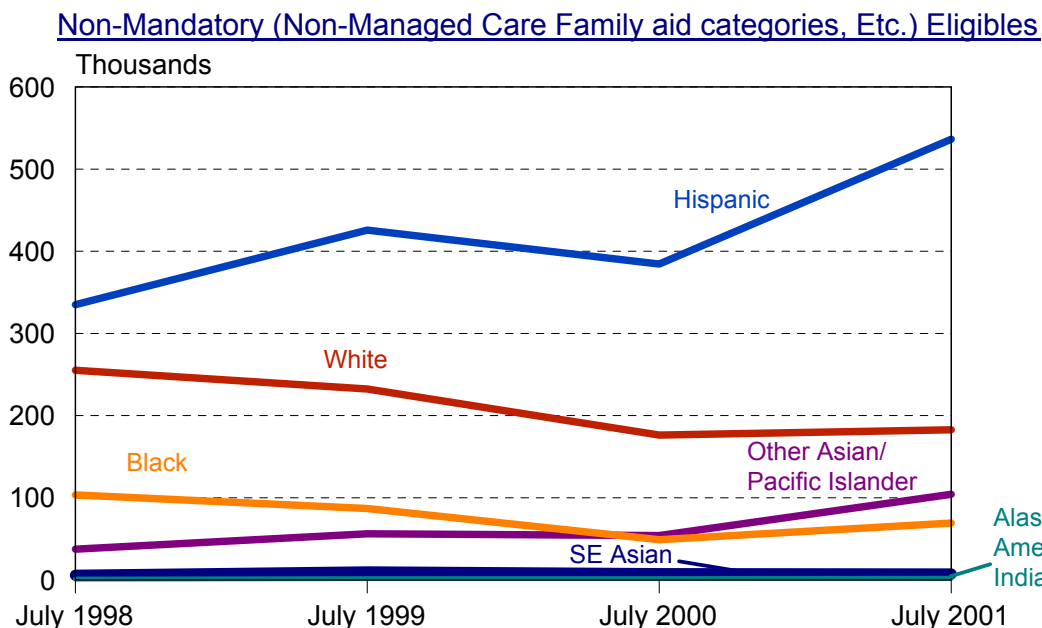
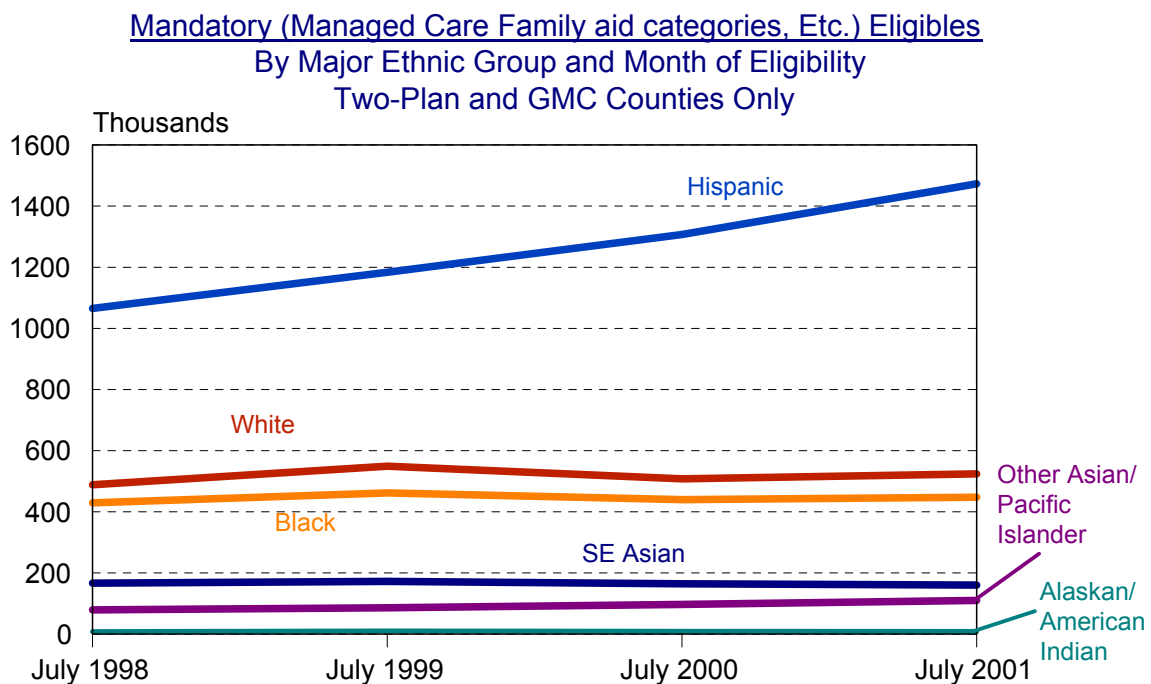


## Section 2, Demographic Characteristics

**Table 2.1, Breakout of Eligibles by Major Ethnic Groups in Two-Plan and GMC Counties**

The following charts show a distribution of the Medi-Cal eligible population in managed care, GMC and Two-Plan counties by major ethnic category. The first chart shows this breakout for the population considered Mandatory (Managed Care Family aid categories, etc.). The second chart covers those not in a Mandatory (Non-Managed Care Family aid categories, etc.) aid category group.

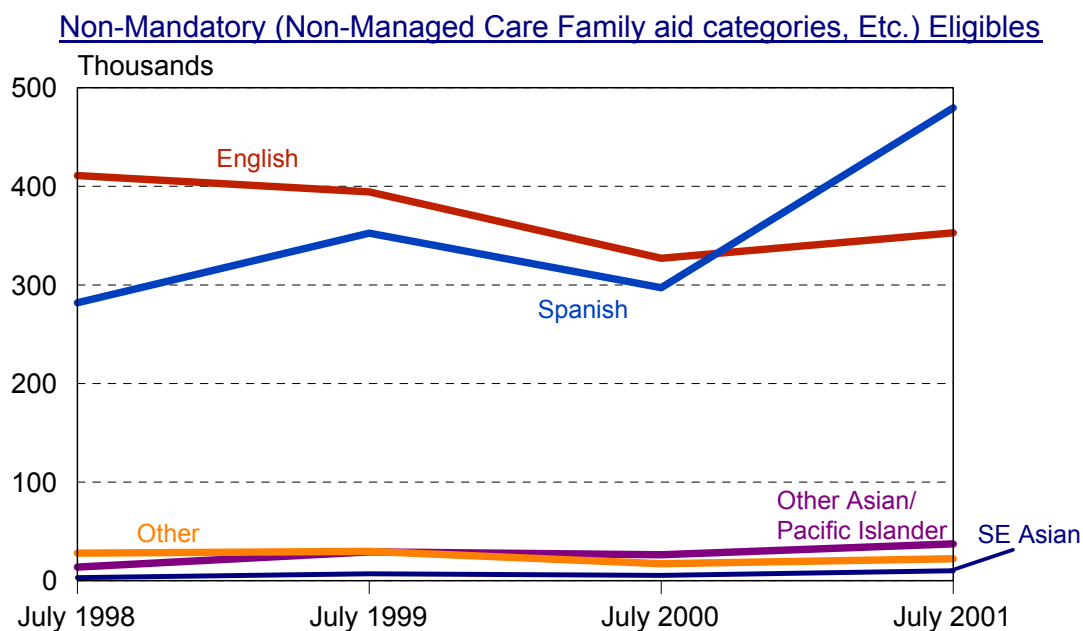
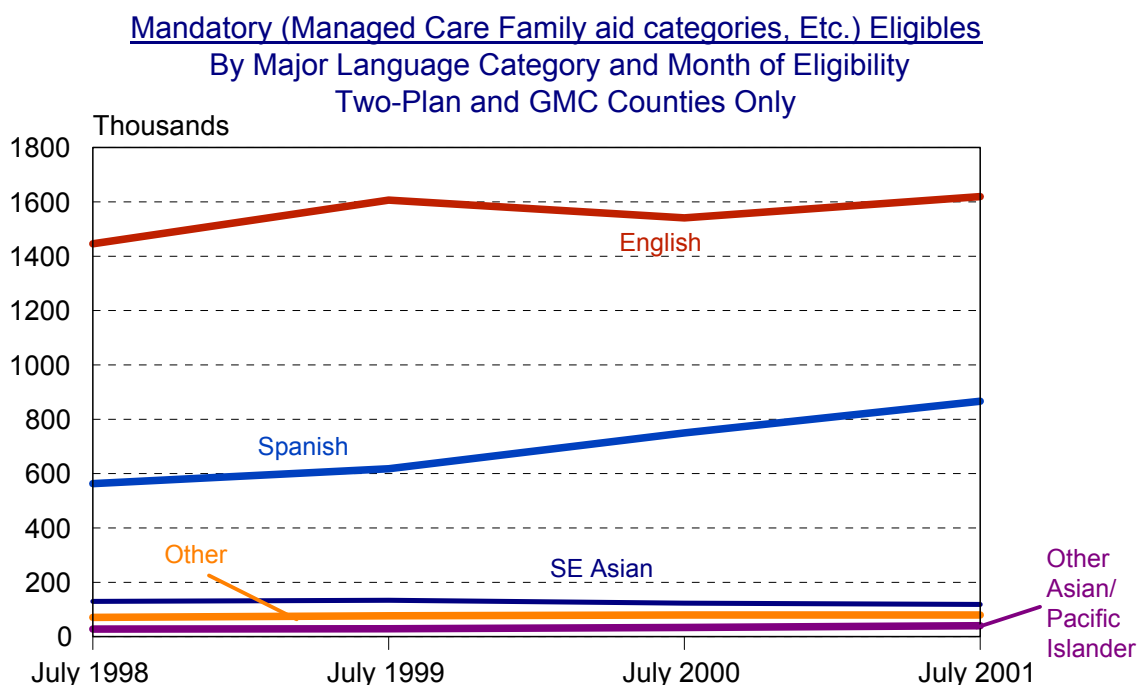
Source of these data is the July 2001 month of eligibility Medi-Cal Eligibles File, using a four-month lag and the [Managed Care Annual Statistical Reports published in 1999, 2000, and 2001](#).



## **Table 2.2, Breakout of Eligibles by Major Language Category in Two-Plan and GMC Counties**

The following charts show a distribution of the Medi-Cal eligible population in managed care, GMC and Two-Plan counties by major language category. The first chart shows this breakout for the population considered Mandatory (Managed Care Family aid categories, etc.). The second chart covers those not in a Mandatory (Non-Managed Care Family aid categories, etc.) aid category group.

Source of these data is the July 2001 month of eligibility Medi-Cal Eligibles File, using a four-month lag and the [Managed Care Annual Statistical Reports published in 1999, 2000, and 2001](#).





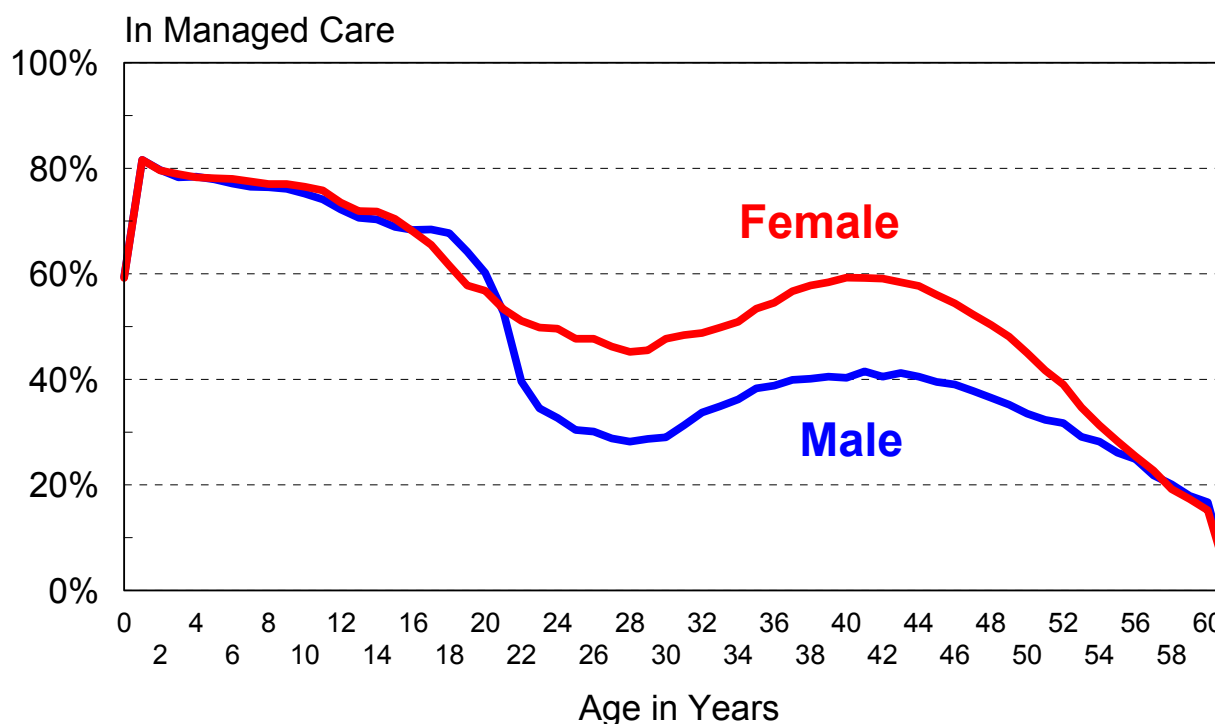
### Table 2.3, Managed Care Enrollment by Age and Gender for Two-Plan and GMC County Eligibles

To understand the medical needs of the Medi-Cal population, it is helpful to know their distribution by age, gender and coverage by managed care. The chart below provides a breakout of those enrolled in managed care, by age and gender, for the Two-Plan and GMC counties for all aid codes.

The chart below illustrates that almost 60% of the children, up to twelve months of age, residing in a Two-Plan/GMC county are in managed care, an increase of 14% since July 2000 (see the [Managed Care Annual Statistical Report published April 2001](#)). This is primarily due to the high rate of retroactivity. Enrollment is considered retroactive if a recipient is found to be qualified for Medi-Cal benefits during the period prior to application; this would result in his or her eligibility being backdated prior to the application date and allow retroactive coverage for medical bills incurred by a recipient prior to the date of application. As mentioned in the narrative for [Table 1.6](#), beneficiaries who are retroactive are not put into these two types of managed care plans. The chart also illustrates that the percent of beneficiaries in a managed care plan remains stable for the female population, but rises briefly (to 68%) for eighteen-year-old males before declining to a more stable 34.5% for twenty-three-year-olds.

Source of these data is the July 2001 month of eligibility Medi-Cal Eligibles File, using a four-month lag; all ages are rounded off.

### Percent of Medi-Cal Eligibles by Age Enrolled in Managed Care in Two-Plan and GMC Counties



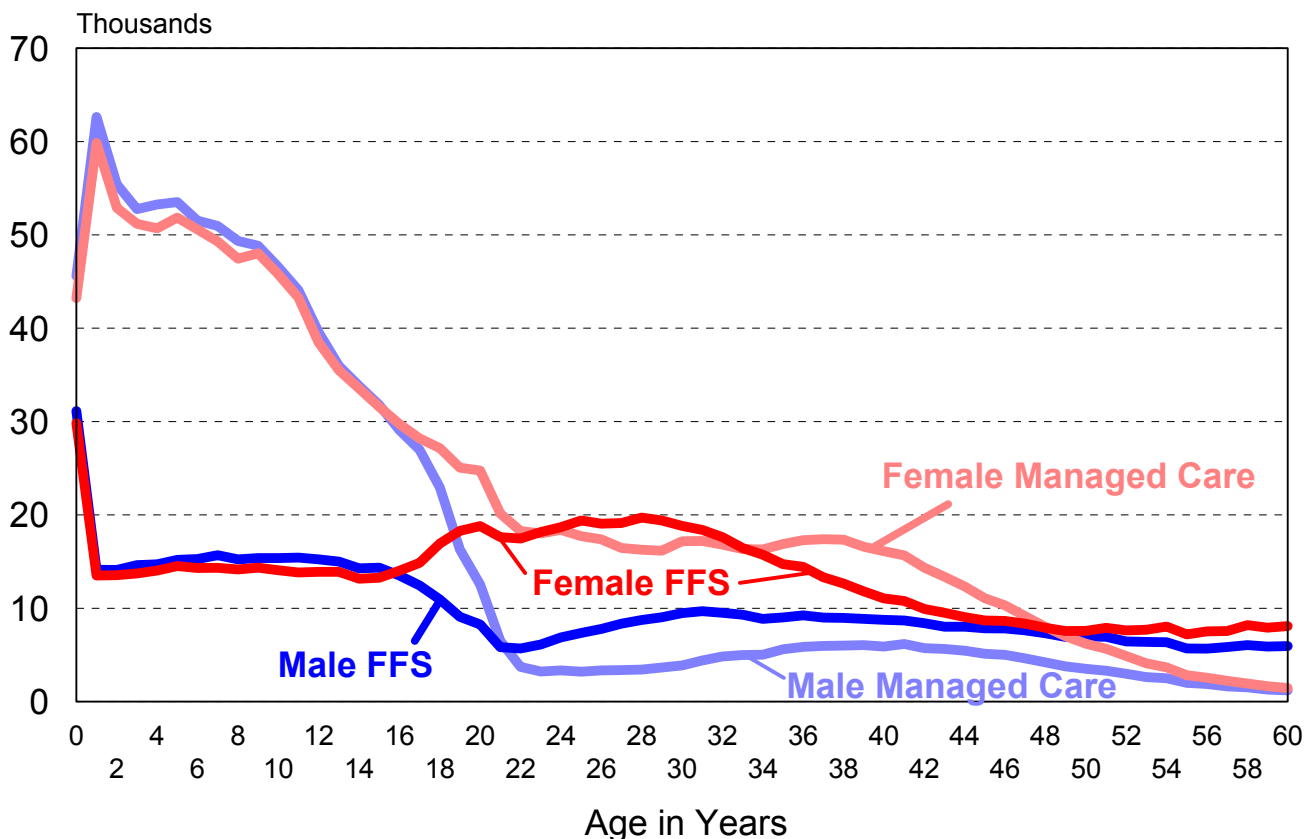


**Table 2.4, Medi-Cal Eligibles Enrolled in FFS vs. Managed Care in Two-Plan and GMC Counties, by Age**

The following chart provides the number of beneficiaries in FFS and managed care for the Two-Plan and GMC counties by age. As reflected in [Table 2.3](#), the number of males in both managed care and FFS drops sharply at about 18 years of age. The number of males in managed care equals the number in FFS at about age 21, whereas the number of females in managed care versus FFS is about the same at ages 23 and 33, and again at age 48. Historically, the number of adult males on Medi-Cal is always less than the number of females.

Source of these data is the July 2001 month of eligibility Medi-Cal Eligibles File, using a four-month lag; all ages are rounded off.

### Number of Medi-Cal Eligibles in FFS vs. Managed Care in Two-Plan and GMC Counties, by Age

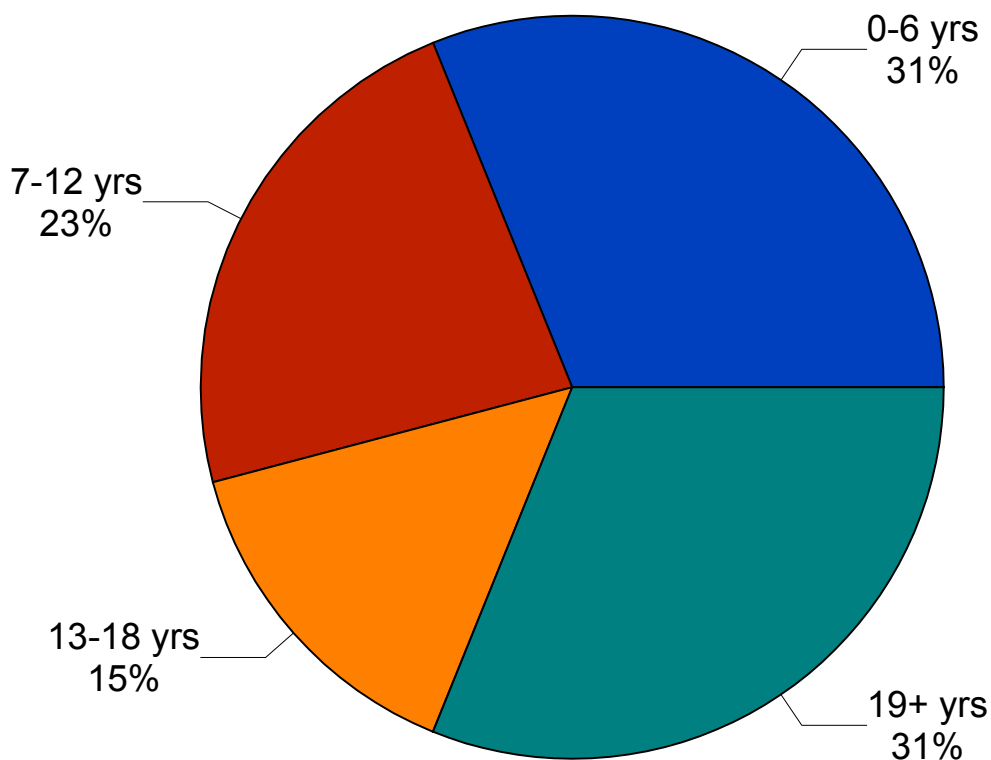


**Table 2.5, Two-Plan and GMC County Managed Care Eligibles by Age Category**

The following chart provides the number of eligibles in a Two-Plan or GMC plan by age, expressed as a percent. As this chart shows, the “19 years of age or over” category and the “six years of age or less” category each reflect almost a third of the Two-Plan and GMC population. The chart also shows that children, less than 19 years old, represent 69% of the Two-Plan and GMC population.

Source of these data is the July 2001 month of eligibility Medi-Cal Eligibles File, using a four-month lag.

**Percent by Age Category of Eligibles in Two-Plan and GMC Plans**



## Section 3, Eligibility Patterns

The length of time someone is enrolled in Medi-Cal is an important factor in the provision of medical services under managed care. The longer and more continuously a person is enrolled in a managed care plan, the easier it should be for a beneficiary to receive preventive and continuous care. Other benefits include the development of a closer relationship between the primary care physician and the beneficiary and less administrative cost to the plan. One way to measure duration of eligibility is to determine how long individual beneficiaries are continuously on Medi-Cal. [Tables 3.1](#) and [3.2](#) provide rates of continuous eligibility for a recent period of time, without regard to a person's pre-existing eligibility. (Note: The Medi-Cal eligibility policy changes implementing Continuous Eligibility for Children and the Elimination of the Quarterly Status Report will increase duration of eligibility; because these were implemented January 2001, their impact is not reflected in this report.)

This "continuity of eligibility" methodology was also applied to the mandatory aid category population for those counties that had implemented Two-Plan and GMC managed care plans. Separate rates were developed for the beneficiaries who stayed in a managed care plan. These rates are shown in [Table 3.3](#).

Another useful measure of the stability of the Medi-Cal population in terms of eligibility is the rate at which new eligibles go on Medi-Cal. One measure of this is the number of eligibles moving from ineligibility to eligibility status, expressed as a percent of all eligibles. This rate was derived for all eligibles as well as just the managed care mandatory aid category population in Two-Plan and GMC counties, and is depicted in [Table 3.4](#).

The converse of measuring Medi-Cal population stability by the rate of new beneficiary enrollment is to measure the rate of beneficiary disenrollments from managed care plans. [Table 3.5](#) shows Two-Plan Model disenrollment rates by reason for disenrollment.

Note: Data for Tables 3.1 through 3.4 were derived from a longitudinal database for a five percent sample of all Medi-Cal beneficiaries, created and maintained by the MCSS. Data for Table 3.5 was derived from the DHS Health Care Options contractor, Maximus, reports.

### **Table 3.1, Continuity of Eligibility in Aggregate**

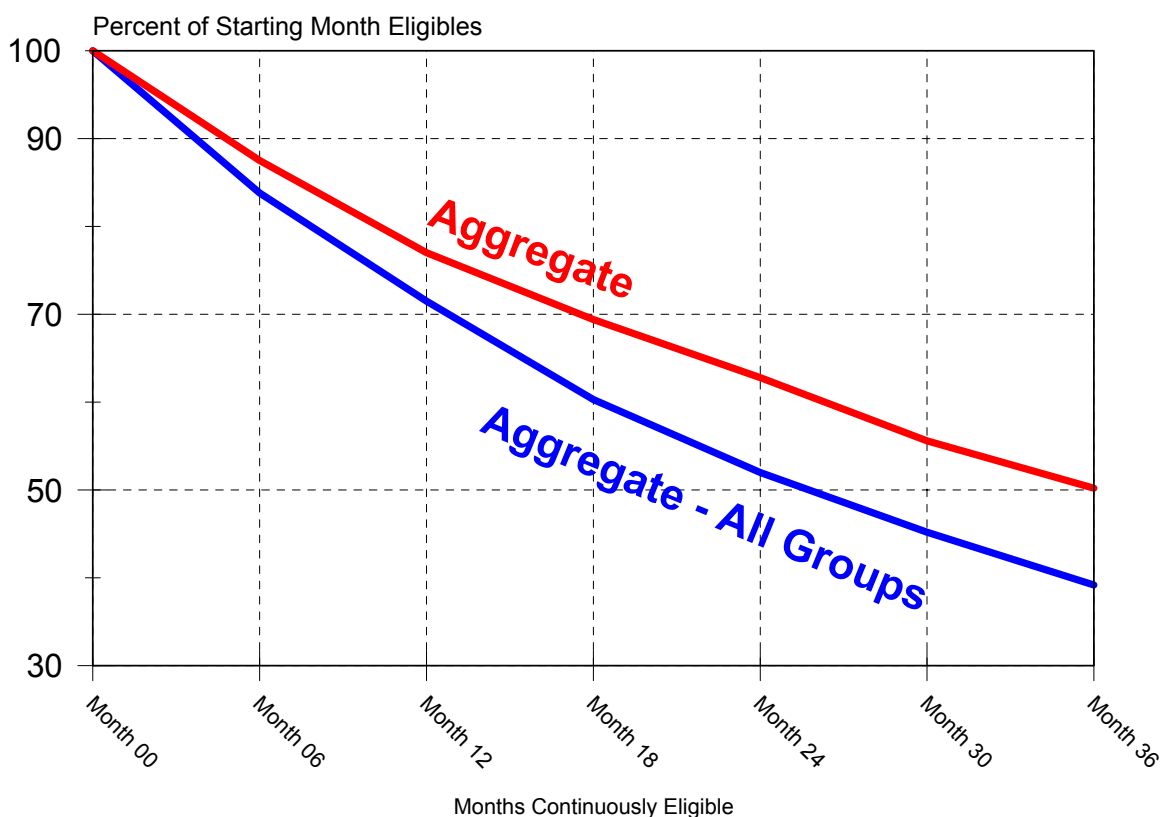
The following chart shows how long a beneficiary would tend to remain eligible for Medi-Cal over a three-year period. The chart reflects eligibility trends as they existed during Calendar Year (CY) 1998 through 2000.

To establish the rates shown below, each beneficiary in the database was tracked for thirty-six months, regardless of their eligibility status in the month immediately preceding the period. Any break in eligibility would drop a beneficiary from being counted at that point. (Studies have shown only a slight difference in the percent continuously eligible when a one-month break is allowed in the definition.)

The curve labeled “Aggregate” shows the rate at which a person who was eligible for Medi-Cal in the first month is likely to remain on Medi-Cal each month for up to thirty-six months. The chart shows that 77% of this population will likely still be on Medi-Cal after the first year, 63% after two years, and 50% after three years. If this population were categorized into seven relatively homogenous eligibility groups, the rate of continuous eligibility for all these beneficiaries (staying within their assigned group) is shown in the chart as “Aggregate – All Groups.” (The difference between the curves is the population who were continuously eligible, but who moved from one group to another.)

Source: A longitudinal database for a five percent sample of all Medi-Cal beneficiaries, created and maintained by the Medical Care Statistics Section, January 1998 thru December 2000.

### Continuous Eligibility in Aggregate January 1998 Thru December 2000



### Table 3.2, Continuity of Eligibility by Major Aid Group

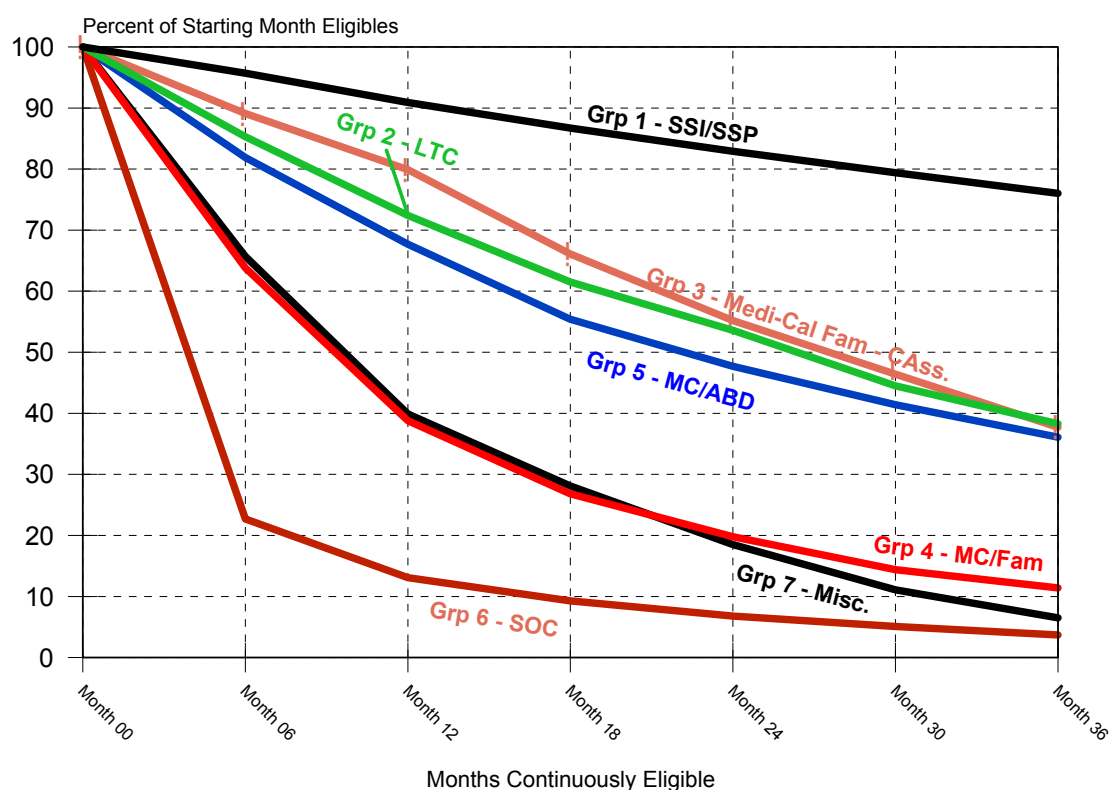
The following chart is similar to [Table 3.1](#), except that eligibles were classified into distinct eligibility groups. Each curve represents those eligibles who continuously belonged to an assigned group for the months shown. If a Medi-Cal eligible either ceased being eligible, or changed to another aid group within this time period, they are excluded from the curve within that six-month period.

It is important to note that this table includes anyone who was eligible the first month of this thirty-six month time frame without regard to their eligibility status in Month 00. A subset of this population is one in which persons were not on Medi-Cal in Month 00, the month prior to the period being considered here. For those interested in this topic, please refer to Table 3.3, Continuity of Eligibility for AFDC – Cash Grant, the [Managed Care Annual Statistical Report published April 1999](#).

The major groups shown in the chart are: 1. SSI/SSP; 2. Long Term Care; 3. Medi-Cal Family-Cash Assistance; 4. Medi-Cal only, Families, No SOC; 5. Medi-Cal only, Aged Blind, Disabled, no share of cost; 6. Share of cost; 7. Miscellaneous. (For a listing of the aid codes making up each of these groupings, refer to the [Appendix, Table A.2.](#))

Source: A longitudinal database for a five percent sample of all Medi-Cal beneficiaries, created and maintained by the Medical Care Statistics Section, January 1998 thru December 2000.

### Continuous Eligibility by Major Aid Group January 1998 Thru December 2000

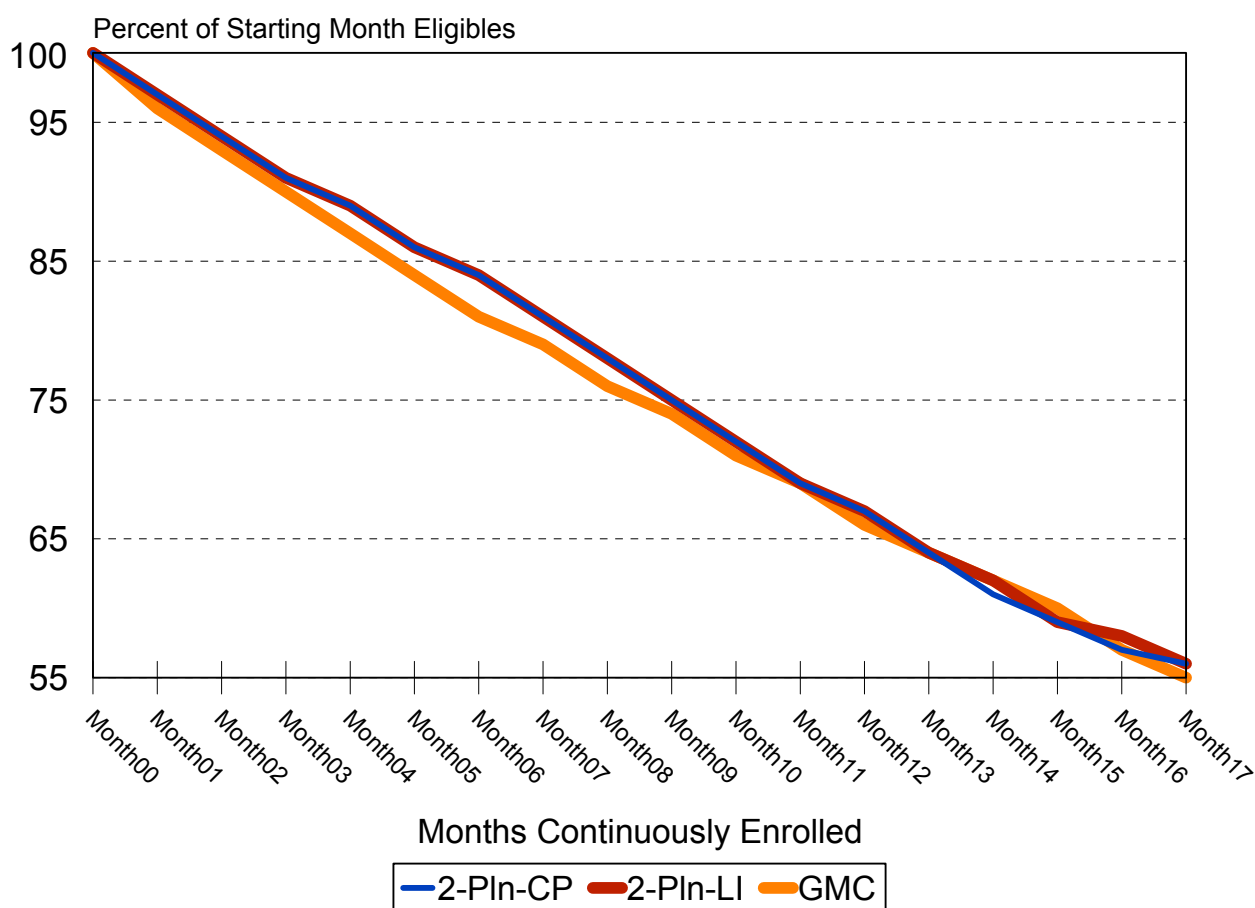


### Table 3.3, Continuity of Enrollment for Two-Plan/GMC Model Plans

The following chart shows the rate at which persons in mandatory aid codes will be continuously enrolled in a managed care plan over a sliding eighteen-month period, with the six starting months of January 1999 through June 1999, for fully implemented Two-Plan and GMC counties. This population may or may not have been on Medi-Cal the month before the starting month of the eighteen-month period used. This population was then followed to determine how long they stayed enrolled in the same managed care plan.

Source: A longitudinal database for a five percent sample of all Medi-Cal beneficiaries, created and maintained by the Medical Care Statistics Section, January 1998 thru December 2000.

## Rate of Enrollment for Two-Plan/GMC Model Plans Mandatory Aid Codes January 1999 Thru December 2000



**Table 3.4, Rate of “Six-Month” and “One-Month” New Beneficiaries on Medi-Cal in Two-Plan and GMC Counties**

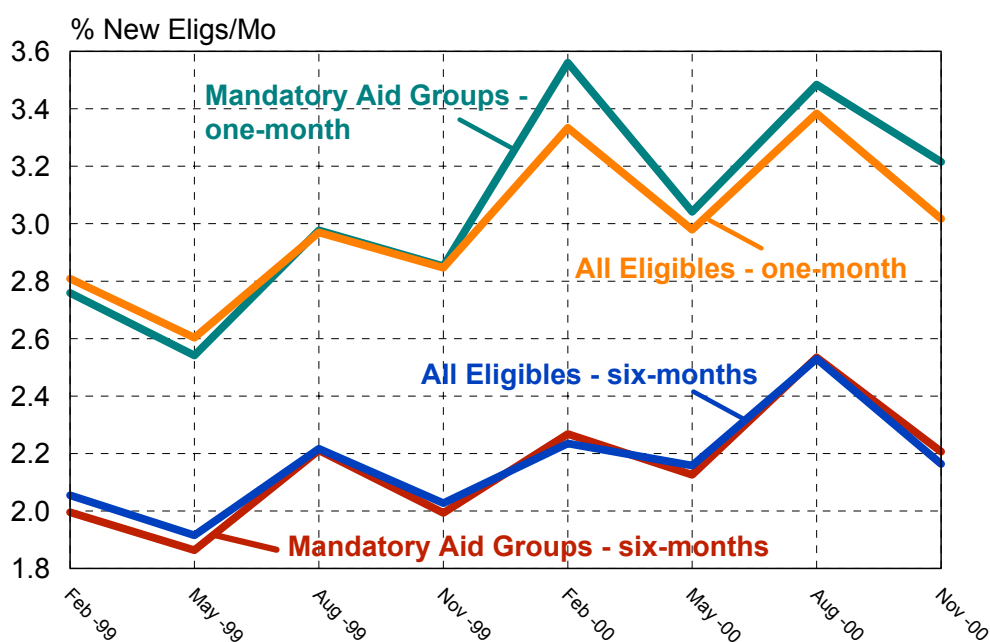
As with continuity of eligibility, the rate at which beneficiaries become eligible for Medi-Cal provides some measure of the turnover of this population. As mentioned, the rate of turnover may be a salient factor in the quality of care provided under managed care. When measuring turnover it is important to distinguish between those beneficiaries who have not been on Medi-Cal for some period of time, and those not on Medi-Cal for at least one-month. The difference should be an approximation of those intermittently, not continuously, enrolled in Medi-Cal.

The following chart compares the rate at which beneficiaries become eligible after being ineligible (not on Medi-Cal) for six-months, i.e., the “new-to-Medi-Cal population” and the rate of those beneficiaries with only one-month of ineligibility. The percentages for the “new to Medi-Cal population” were derived by first calculating a denominator of a count of eligibles for the months February, May, August, and November for the calendar years 1999 through 2000. A subset of this population, those ineligible the previous six-months, was used to calculate a percent or rate of those “new” to Medi-Cal. The same methodology was used to develop a rate for the “mandatory” population, those most likely to be in a managed care plan in Two-Plan Model and GMC counties.

As this chart shows, when the definition of “new eligible” is relaxed from six-months of ineligibility to one-month, the percentages increase significantly.

Source: A longitudinal database for a five percent sample of all Medi-Cal beneficiaries, created and maintained by the Medical Care Statistics Section, January 1999 thru December 2000.

**Rate of New Medi-Cal Eligibles  
After One-Month or Six-Months of Being Ineligible  
Mandatory Aid Groups vs. All Eligibles  
for Calendar Years 1999 and 2000  
in Two-Plan and GMC Counties Only**



### Table 3.5, Rate of Disenrollments from Two-Plan Model County Plans

[Table 3.3](#), Continuity of Enrollment for Two-Plan/GMC Model Plans, suggests that the GMC plans and both types of Two-Plan Model plans, the Commercial Plan and the Local Initiative, have similar member retention rates. The methodology for deriving those rates followed beneficiaries in each plan for eighteen months, with a variable starting month of January through June 1999. Measuring such continuity of eligibility is an indirect way of quantifying member satisfaction with their managed care plan, based on the assumption that dissatisfied members would switch plans, thereby contributing to overall lower plan rates.

Perhaps a more direct way to examine this issue is to determine the rate of beneficiary disenrollments from plans. The number of members disenrolled from each Two-Plan Model health care plan was obtained from the Health Care Options contractor, Maximus, for the months January through June 2001. Even though this period overlaps only partially with the periods used for establishing the enrollment rates shown in [Table 3.3](#), it is intriguing that the disenrollment rates for the Commercial Plans (CPs) is significantly higher than for the Local Initiatives (LIs), that is, 6.06 and 2.51, respectively. A higher disenrollment rate does not necessarily suggest dissatisfaction by beneficiaries with their plans, but research into other possibilities is needed. It should also be noted that enrollment attrition rates cited in last year's report (see [Table 3.3, Managed Care Annual Statistical report, April 2001](#)) showed that the Commercial Plans had a higher retention rate than the Local Initiative ones, a fact contrary to the data presented below covering the period January through June 2001.

**Table 3.5, Disenrollment Rates per 1000 Beneficiaries for  
Two-Plan Model Plans, by Reason**

	<u>All</u>	<u>CP</u>	<u>LI</u>
All Reasons	3.74	6.06	2.51
Beneficiary Preference/Health Plan Did			
Not Meet Needs	3.11	5.07	2.07
Did Not Choose Plan	0.20	0.35	0.12
Could Not Choose Doctor	0.16	0.26	0.11
Doctor Did Not Meet Beneficiary's Needs	0.10	0.17	0.07
Too Far To Go	0.06	0.09	0.04
Medical Exemption	0.05	0.07	0.05
Moved Out of County	0.05	0.04	0.05
All Other	0.01	0.01	0.01

Source: DHS Health Care Options contractor, Maximus.

## Appendices

[Appendix, Table A.1](#), List of Aid Categories by Managed Care Model and Type of Membership Status

[Appendix, Table A.2](#), List of Aid Codes by Major Grouping Used for Continuous Eligibility Charts in [Section 3](#)

## Appendix, Table A.1, List of Aid Categories by Managed Care Model and Type of Membership Status Page 36

The following table provides a list of aid categories that are considered mandatory (M), vs. voluntary (V), vs. other (o) [can't join] for each plan model. (Note: This table was current as of May 2001. For a current table, contact the DHS Medi-Cal Managed Care Division.)



	COHS		GMC	Two-Plan	FFS/ MC	PHP/ PCCM
Aid Cat.	Monterey, San Mateo, & Yolo	Napa, Orange, Santa Barbara, Santa Cruz, & Solano	Sacramento & San Diego			
0A	M	M	M	M	V	V
01	M	M	M	M	V	V
02	M	M	M	M	V	V
03	M	M	V	V	V	V
04	M	M	V	V	V	V
08	M	M	M	M	V	V
10	M	M	V	V	V	V
13	M	M	o	o	o	o
14	M	M	V	V	V	V
16	M	M	V	V	V	V
17	M	M	o	o	o	o
18	M	M	V	V	V	V
1H	M	M	V	V	V	V
20	M	M	V	V	V	V
23	M	M	o	o	o	o
24	M	M	V	V	V	V
26	M	M	V	V	V	V
27	M	M	o	o	o	o
28	M	M	V	V	V	V
30	M	M	M	M	M	V
32	M	M	M	M	M	V
33	M	M	M	M	M	V
34	M	M	M	M	M	V
35	M	M	M	M	M	V
36	M	M	V	V	V	V
37	M	M	o	o	o	o
38	M	M	M	M	M	V
39	M	M	M	M	M	V
3A	M	M	M	M	M	V
3C	M	M	M	M	M	V
3E	M	M	M	M	M	V
3G	M	M	M	M	M	V
3H	M	M	M	M	M	V
3L	M	M	M	M	M	V
3M	M	M	M	M	M	V
3N	M	M	M	M	M	V
3P	M	M	M	M	M	V
3R	M	M	M	M	M	V
3U	M	M	M	M	M	V
40	M	M	V	V	V	V
42	M	M	V	V	V	V
45	M	M	V	V	V	V

Appendix, Table A.1, List of Aid Categories by Managed Care Model and Type of Membership Status Page 37



	COHS		GMC	Two-Plan	FFS/ MC	PHP/ PCCM
Aid Cat.	Monterey, San Mateo, & Yolo	Napa, Orange, Santa Barbara, Santa Cruz, & Solano	Sacramento & San Diego			
47	M	M	M	M	V	V
4A	M	M	V	V	V	V
4C	M	M	V	V	o	V
4F	M	M	V	V	V	V
4G	M	M	V	V	V	V
4K	M	M	V	V	o	V
4M	M	M	V	V	V	V
53	M	M	o	o	o	o
54	M	M	M	M	M	V
55	M	o	o	o	o	o
58	M	o	o	o	o	o
59	M	M	M	M	M	V
5F	M	o	o	o	o	o
5G	M	o	o	o	o	o
5K	M	M	V	V	o	V
5N	M	o	o	o	o	o
5X	M	M	M	M	M	V
60	M	M	V	V	V	V
63	M	M	o	o	o	o
64	M	M	V	V	V	V
65	M	M	o	o	o	o
66	M	M	V	V	V	V
67	M	M	o	o	o	o
68	M	M	V	V	V	V
6A	M	M	V	V	V	V
6C	M	M	V	V	V	V
6H	M	M	V	V	V	V
6N	M	M	V	V	V	V
6P	M	M	V	V	V	V
6R	M	M	V	V	V	V
6V	M	M	o	o	o	o
6W	M	M	o	o	o	o
6X	M	M	o	o	o	o
6Y	M	M	o	o	o	o
72	M	M	M	M	V	V
7A	M	M	M	M	M	V
7J	M	M	V	V	V	V
7X	M	M	M	M	M	V
81	M	M	o	o	o	o
82	M	M	M	M	V	V
83	M	M	o	o	o	o
86	M	M	V	V	V	V
87	M	M	o	o	o	o
8P	M	M	M	M	V	V
8R	M	M	M	M	V	V



**Appendix, Table A.2, List of Aid Codes by Major Grouping Used For  
Section 3, Table 3.2 Continuity of Eligibility by  
Major Aid Category Group**

<u>Aid Code Groups</u>	<u>Aid Codes</u>
1. SSI/SSP	10, 12, 18, 20, 22, 25, 28, 60, 62, 68, 6N, 6P
2. Long Term Care	13, 23, 53, 63
3. Medi-Cal Family-Cash Assistance	06, 30, 32, 33, 35, 38, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3P, 3R, 3U, 3W, 40, 42, 43, 46, 4C, 4F, 4G, 77, 78
4. Medi-Cal only, Families, No SOC	03, 04, 07, 2A, 34, 39, 3N, 3T, 3V, 44, 45, 47, 48, 49, 4A, 4K, 4M, 54, 59, 5J, 5K, 5M, 5T, 5W, 5X, 5Y, 69, 6J, 70, 72, 74, 75, 76, 79, 7A, 7C, 7F, 7G, 7J, 7K, 7M, 7N, 7P, 7R, 82, 86, 8E, 8N, 8P, 8R, 8T
5. Medi-Cal only, ABD, No SOC	14, 15, 16, 1G, 1H, 1U, 24, 26, 2G, 36, 64, 66, 6A, 6C, 6G, 6H, 6U, 6V, 6X
6. Share of Cost	17, 27, 37, 5R, 65, 67, 6R, 6W, 6Y, 83, 87
7. Miscellaneous	01, 02, 08, 0A, 51, 52, 55, 56, 57, 58, 5F, 5G, 5H, 5N, 71, 73, 7H, 80, 81, 8G